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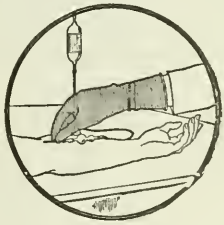

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NEUROLOGY.

INFLUENZA AND HYPOPHRENIA.

MENNMYER, K. A. (*Jour. A. M. A.*, Oct. 10, 1920) writes on the interrelation of an acute epidemic infection and a chronic endemic (brain) affection and concludes that:

1. The usual effect of influenza on the brain is not the production or precipitation of hypophrenia, and, if it ever produces hypophrenia it is probably by means of a more or less obvious encephalopathy.

2. On the other hand, of those already manifesting mental lack, certainly a few are influenced adversely by influenza, and the symptoms of hypophrenia aggravated, an aggravation which may be predominantly in the intellectual sphere, in the emotional sphere or in the volitional sphere.

3. Psychoses of an indeterminate type are occasionally precipitated by influenza in the feebleminded, even as in normal persons.

4. At least occasionally, though rarely, the effect of influenza on hypophrenia may be symptomatic amelioration. [E. H. R.]

GYNECOLOGY.

JOINT DISCUSSION ON THE TREATMENT OF UTERINE FIBROIDS.

KNOX (*Brit. Med. Jour.*, Oct. 9, 1920), discussing the radium treatment of fibroids, gives the contraindications of such treatment by x-ray or radium as follows:

1. It is obvious that if a large portion of the fibroid has become converted into calcareous matter, and if the tumor is of large size, x-rays can have no beneficial effect. In doubtful cases a radiographic examination will reveal the extent of the degenerative change.

2. Most forms of degeneration should be excluded before x-rays are administered, though, if not very extensive, the treatment may be tried.

3. Malignant disease of the uterus calls for very careful consideration. Operative measures should be discussed. If it is impossible to remove the tumor, then there is no objection to a combined attack on the disease by x-rays and radium. Very careful application of radium tubes is necessary, and for this a general anesthetic is indicated.

4. Infective conditions of the uterus complicating fibroids.

5. Suppurative salpingitis or pelvic peritonitis.

6. Inflammatory conditions of other organs in the vicinity—namely, appendicitis, cystitis—should be dealt with before attempting to treat the fibroid.

7. Submucous pedunculated fibroids.

(Continued on page vi.)

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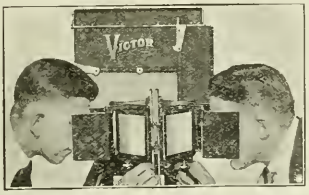

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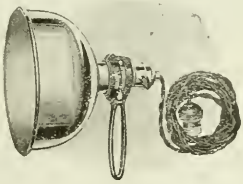

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(Continued from page iv.)

He presents the advantages and disadvantages of x-ray treatment as follows:

Advantages.

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2. The patient can live her ordinary life, merely arranging for one or two days' rest after each treatment.
3. No elaborate preparations are required.
4. The resulting menopause is not usually attended by such severe nervous disturbances as those following operation.
5. In patients whose general health is much impaired, the recovery is rapid when the hemorrhage is arrested; moreover, the shock so often inseparable from hysterectomy is entirely obviated.

Disadvantages.

1. It takes a considerable time to effect a result —treatments may have to be given at intervals for some months.
2. The treatment is not invariably successful.
3. The tumor, though as a rule much reduced in size, does not entirely disappear.
4. Treatment may cause unfavorable changes in the blood. [J. B. H.]

MEDICINE.

Radium in the Treatment of Malignant Tumors of the Nose and Throat. Its Use and Possible Abuse.

Sonnenshein, R. (*Jour. A. M. A.*, Sept. 25, 1920).

1. The future of radium therapy seems very bright, particularly in reference to applications in tumors of the nose and throat; but great caution is advisable in statements regarding actual cures. It is important to watch for recurrences during a period of from two to five years.
2. In reporting cases, authors should give details of the preparation used, the method of application, duration of exposure, etc., in radium treatments.
3. Following up the cases and reporting on them again whenever possible is of the utmost importance in the formulation of definite conclusions regarding radium treatment.
4. Radium is probably of great value before, and certainly after operations. It is very efficient in relieving pain, hemorrhage, discharge, etc., in many inoperable cases.
5. Sarcomata are especially responsive to radiation; the carcinomata yield much less readily, and the squamous type of epithelioma is scarcely amenable to radium at all.
6. Complications, at least those reported, are not so frequent as one would be likely to expect. Burns were the most common ones, but even death may result from toxemia.
7. Radium has many advantages as compared with roentgen rays, especially for application in the nose and throat.
8. The diagnosis of the malignant cases should be made by a competent laryngologist, and the radium

(Continued on page viii.)

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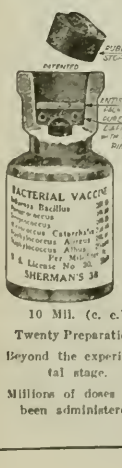

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(Continued from page vi.)

applied either by him or in coöperation with a radiologist. Only in this way will correct statistics and reliable results be obtained, with greatest benefit to the patient and the safest guidance to the profession.

]E. H. R.[

The Effects of Radium Treatment on War Injuries in the Neighborhood of Nerves.

Stevenson, W. C. (*Brit. Med. Jour.*, June 26, 1920), presenting the various cases illustrative of the effects of radium in war injuries in the neighborhood of nerves, summarizes his work as follows:

1. Radium treatment cannot benefit gross nerve lesions; here operative treatment is indicated to unite severed nerves or free them from dense scar tissue.

2. After a nerve operation, or after milder degrees of nerve trauma, it would appear to aid to hasten the return of function to a limb.

3. It improves the nutrition in the area supplied by injured nerves.

4. It may be useful as an aid to diagnosis, and in certain cases will indicate or contraindicate the necessity of operation.

5. It is a valuable adjunct to other forms of treatment. [J. B. H.]

The Labyrinthine Reactions of Experienced Aviators.

Ranken (*Brit. Med. Jour.*, June 26, 1920) discusses the labyrinthine reactions of experienced aviators with the following conclusions:

1 Experienced pilots have, if anything, a slight tendency toward diminished labyrinthine reactions.

2. Disturbance, present or past, of some other system of the body may affect labyrinthine reactions.

3. Where deafness is present, no medical examination of a candidate or pilot is complete without a careful investigation of the functions and reactions of the semicircular canals of both sides.

4. In the absence of a discovery of present or past signs or symptoms pointing to an aural affection, routine examination by means of the Barany tests is superfluous, provided that a thorough general examination is made. [J. B. H.]

The Practical Application of Vaccine Prophylaxis and Treatment.

Lowe, E. C. (*The Practitioner*, October, 1920) is an enthusiastic believer in the value of vaccine therapy in the prophylaxis of acute catarrh conditions which are most common during the winter. He believes that vaccines will do good if they are of the right kind but that they are capable of doing harm also.

He is of the opinion that vaccine therapy will, in the future, occupy a much more prominent place in clinical, pathological work than it does at present.

[J. B. H.]

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[ ] **GYNECOLOGY**

[ ] **OBSTETRICS & PEDIATRICS**
- (a) Obstetrics
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[ ] **MEDICINE & PHYSIOLOGY**
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- (b) Internal and Metabolic Conditions
- (c) Endocrinology
- (d) Cardiovascular Conditions
- (e) Respiratory Conditions
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- (c) Serology and Hematology
- (d) Pathology
- (e) Research
- (f) Biology and Organic Chemistry

[ ] **ROENTGENOLOGY & RADIOTHERAPY**

[ ] **SEXOLOGY**

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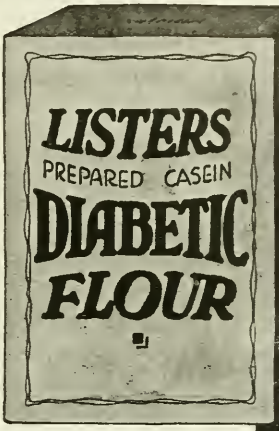

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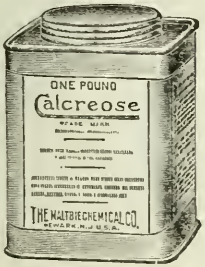

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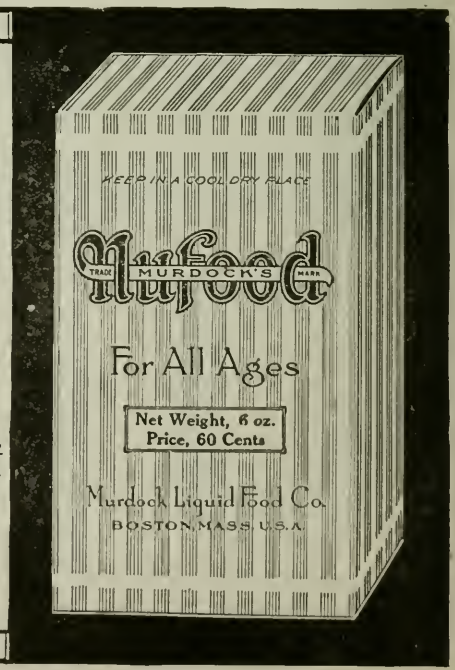

The Boston Medical and Surgical Journal

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Address.

NEW ENGLAND SURGICAL SOCIETY. PRESIDENTIAL ADDRESS.*

BY HOMER GAGE, M.D., WORCESTER, MASS.

Fellows of the New England Surgical Association:

I wish I were able adequately to express my appreciation of the honor conferred upon me at your meeting last year. To be privileged to preside over this representative body of New England surgeons is a distinction of which any member of our profession may justly be proud.

Although fully conscious of how little I have done to deserve it, I am, however deeply grateful for this expression of your confidence and shall always feel that it imposes upon me an obligation to do all that I can to strengthen our association and to make an effective force in maintaining the high standard of New England surgery.

We made a good start at a bad time. Our first meeting at Boston was very successful, and we were all eagerly looking forward to a meeting at Burlington the next Fall. We knew that we should be welcomed to one of the beauty spots of America, among the green hills of Vermont, by a demonstration of that good old-fashioned New England hospitality for which that state has always been famous.

But the great war came, and instead of the anticipated pleasure of the Burlington meeting, most of us went into government service of one sort or another, and our Association presented a picture of suspended animation. Suspended only—mark you—for as soon as we got back into our old places we began to agitate for a revival, and the meeting at Boston last year put us on our feet again.

We meet here in the old Providence Plantations under the most favorable circumstances, where, true to the traditions of its founder, there is a wide tolerance of every variety of opinion, with a strong feeling against the fanatical curtailment of our personal liberties and the infringement of the right to decide each for himself, how we may most appropriately satisfy the thirst from which man always has and always will suffer.

All this naturally suggests a little consideration of the reasons for forming this organization of ours, and for maintaining its independence in an already somewhat over-organized community.

Geographically New England has always been naturally isolated from the rest of the country,—its varied landscape of mountains, lakes

* Delivered at the meeting on Oct. 7, 1920, in Providence, R. I.

and rocky coast have made it quite distinguished as the most popular vacation ground of America. The variety and richness of its autumnal coloring cannot be matched anywhere else.

Moreover, its severe winters and its rough and rocky soil have produced a hardy race of men and women;—"intelligent and intellectually vigorous, hospitable, neighborly, much given to reading and reflection, and scrupulously conscientious with regard to their obligations to each other and the world; who grasped the great moral, religious, and political questions of the day and discussed them with a clearness of insight nowhere surpassed." This description by a loyal son of Maine, himself a surgeon and the son of a physician, of the men and women of his native town, is applicable of all New England, and defines pretty well what we mean when we speak of the New England type,—it defines what we mean by New England character and New England conscience. It applies to medical education, to medicine and surgery.

There is something about New England education and training in surgery, certain ideals in regard to the practice of surgery that are different. I would not for a moment be understood as expressing the opinion that they are better, but I do believe that they are perfectly characteristic, and am equally convinced that they are worth perpetuating.

The Southern Surgical Association and the Western Surgical Association and other local associations have already a record of great accomplishment. Our opportunity is certainly as great, and our obligation is greater, for none of them can match the wealth of New England tradition which we inherit.

Think of the boldness of Zabdiel Boylston, who made the first inoculation of smallpox in this country upon his own son, and for his advocacy of this first attempt at preventive medicine was villified by his professional brethren and forced to secret himself in his own house for 14 days to prevent being lynched; but who lived to be invited to London by Sir Hans Sloane, to publish in London the first book on inoculation, and to receive a large grant from the King in recognition of his services to humanity.

In 1800, Dr. Benjamin Waterhouse, first Professor of Theory and Practice, made the first inoculation of cow pox in America upon his four children, and later exposed them to smallpox to prove the efficacy of his virus.

Then think for a moment of the courage of Morton and John C. Warren in operating upon Gilbert Abbott on October 16, 1846, at the Massachusetts General Hospital under ether,—thus giving the first public demonstration of its use as an anesthetic, the first public proof of its efficiency, its safety, and its general applicability;—and do not forget that Warren was but one of four generations of eminent surgeons of the same name who have contributed much to the traditions we enjoy.

Nor must we overlook Henry J. Bigelow and his pioneer work on the operation of litholapaxy, and the anatomy of the hip-joint; a great teacher and dominating figure in the history of New England surgery for more than a generation.

These men were all from Boston or vicinity, but many of our best traditions come from the smaller New England towns. It was in the remote country districts that the people without our means of swift travel and communication in wrestling with the problems of philosophy, science, religion, and life in general, developed the sturdy character and intellectual supremacy that marked the descendants of the Pilgrims and the Puritans.

A farmer's boy, whose life had been spent in the then wilderness of northern Vermont, was called upon to assist a local surgeon, withal a man of character, influence and considerable surgical accomplishments, in the amputation of a leg.

Fired with an ambition to become a surgeon he offered himself at once to his principal as an apprentice, after the fashion that then prevailed. The unselfish wisdom of the doctor prescribed a preliminary course of study equivalent to the requirements of admission to Harvard College. This he did, then three years' apprenticeship with his preceptor, and for the next three years he practised his profession in Cornish, New Hampshire.

Conscious of his own shortcomings and ambitious to improve, in spite of very limited resources he went to Boston and took a course of lectures at the new Harvard Medical School, was graduated M.B., 1790, and went back to the northern country.

Impressed with the uneducated character of the physicians of that section and their lack of opportunity to acquire knowledge, he enlisted

the interest of President Wheelock of Dartmouth, and the Medical Institute at Hanover was started.

That he might be the better qualified to teach, he took a sailing vessel for England and studied in Edinburgh and London and was gone a year.

Then followed ten years of teaching and hard riding over the hills of New Hampshire and Vermont, but he had the satisfaction of seeing his classes grow from 20 to 60, and his school established in high repute.

He was then called to the chair of Surgery in the New Medical School at Yale, and there he spent the rest of an honored life. But he found time besides his lectures at Yale, to give a course of lectures at Burlington, one at Dartmouth, and two at the Bowdoin School at Brunswick, Maine.

He also made many valuable contributions to the medical literature of his time,—notably a remarkably clear and vivid description of his first case of extirpation of the ovarian sac,—done six years after McDowell's pioneer work, but without knowledge of its existence.

These were the accomplishments of Nathan Smith, who stamped his indelible impress upon the medicine and surgery of northern New England, and has left us a tradition of industry and unselfish devotion to the interests of his patients and his profession, in marked contrast to the growing tendency to commercialism in medical practice.

One of his most distinguished pupils was the son of a New Hampshire farmer, who after failing to be accepted at Harvard was matriculated at Dartmouth, and graduated with the degree of A.B. in 1802.

A natural inclination toward medicine was fostered by the influence, example and friendship of Nathan Smith, and as a result, Amos Twichell became the chief practitioner and consultant of the northern country.

His ability to recognize and courage to operate for abscess of the tibia, and his successful ligature of the common carotid artery, the first successful case in our records, attest his surgical judgment and skill; that he had an opportunity to decline the professorship of surgery at Hanover, Castleton, Brunswick and Burlington, is sufficient evidence of the esteem in which he was generally held, and the wide extent of country over which his reputation was recognized and appreciated. His name still endures among descendants of those whom he faithfully and unselfishly served for so many years.

Pardon me if for a moment I refer to one more great New England surgeon of a later generation. Born in the backwoods of Maine, in a township among whose beautiful hills and lakes my grandfather toiled with the devotion and self-sacrifice of an old-fashioned country doctor, like many an unsung hero of our profession, William Warren Greene became a surgeon of more than national reputation.

His pioneer work in the development of the operation for the removal of the bronchocele was perhaps his most important contribution to surgery, but his charming personality, enthusiasm, and clearness of expression, combined with his great technical ability as an operator, made him one of the great surgical teachers of his time and generation.

Now these three men were not accidents; they were merely conspicuous examples of the kind of men that the country districts of New England have been producing from the time of their earliest settlement,—strong, self-reliant men, but full of sympathy, eager to learn, and anxious to serve, devoted to their profession, and finding their chief reward and highest satisfaction in the gratitude and affection of those among whom they lived and labored.

From such men as these, as well as from those who have made the important contributions to the advancement of surgery and surgical practice, to which we have already alluded, we have received certain traditions and ideals respecting our obligations and responsibilities to our patients, and to each other, which we are proud to inherit, and are in duty bound to keep alive and transmit to those who come after us.

In the fulfillment of this obligation I believe this association of New England surgeons can and should play an important part.

We have met as members of our state and national societies, but we have only just gotten together as New Englanders, inheriting the same traditions and inspired by the same ideals; and there surely could be no more appropriate time than this tercentenary of the landing of the Pilgrims to reconsecrate ourselves to the pursuit and the perpetuation of their splendid spirit.

Now, the lesson which we ought to learn from the study of their lives and character is the obligation to attack the problems of our generation with the same sort of courage, candor and earnest purpose to heal and to help those who have

placed their trust and their lives in our hands, that our fathers used in facing their problems.

As an example, I trust you will pardon me for calling your attention to one present-day problem which I think is deserving of our most careful consideration, and is of vital importance to us all. I refer to the relation of our hospitals to the public and to the surgeon.

It is not many years since hospitals were few in number, and confined almost exclusively to the larger centers of population. It was very difficult to persuade patients to go to a hospital, and their friends to permit them to go. There was a universal dread of hospital residence, and only those entered who could not possibly be cared for at home. How different all this is now. By all classes, rich and poor, the hospital is now regarded as the safest and most appropriate place for the sick and injured.

The effect of this change of feeling is very clearly seen in the constant enlargement of existing institutions, and the remarkable increase in the number of small community hospitals. There have also sprung into existence many hospitals that are purely private business ventures. Some have a compact and selected staff of physicians and surgeons,—many have no staff at all, but are open to any licensed and approved practitioner who may choose to apply for the admission of his patients.

Their financial support comes in some instances, from paying patients, in some, from city or town appropriation; in others, from gifts, donations and bequests, in all cases it is the public who pays the bill; and the public has a right to demand that the service rendered shall be the best that the profession in that community can afford.

To no appeal has there been a more general or more generous response than to the appeal for funds for hospital support. But it is quite apparent that the response is beginning to come a little more hesitatingly, and to be more often accompanied by questions as to the character and quality of the work done, and as to the economy and efficiency of management.

This is well illustrated by the action of the Federated Charities of Cleveland, from whose drive all the organized charities of the city, including the endowed hospitals, derive their support.

In order to be sure that the hospitals deserved support, and how much support each needed, a complete survey of them all has been ordered, and is about finished.

So far as such a survey relates to matters of hospital administration, our interest is that of every member of the community; so far as it relates to the treatment of patients and the results of treatment, our interest is greater than that of anyone else.

It is of vital importance to us that the confidence of the people in the hospitals shall not be lost or lessened. The profession, and especially our branch of it, has already taken notice of this tendency, and a complete survey of all the hospitals in the United States and Canada, having 100 beds or more, by the American College of Surgeons is now nearing completion.

The American Medical Association, the American Hospital Association, the American Nurses' Association, and the Social Service Workers are all asking to be allowed to participate in order that the survey may be broader and more comprehensive. As the investigation is continued so as to include the smaller institutions, their coöperation seems highly desirable.

The title of Hospital Standardization has been given to this work, and to this I think reasonable objection may be raised as being somewhat misleading. It reminds me of an inspector from the Surgeon General's office who proposed that the camp hospitals should standardize their operations,—have a standardized operation for hernia, another for appendicitis, etc., so that they could be more easily classified and the results compared. It simply cannot be done.

Surgical procedures cannot be standardized and classified like the processes involved in the making of a machine or the building of a bridge. Questions like: when to operate, how to operate, how far operative interference shall be pushed and when it is to be refused, involve a good deal more than technical skill,—they involve that most important and most valuable quality of our profession, sound surgical judgment, and that defies rules and regulations. It cannot be cast in a mould.

The American College of Surgeons in its survey has no intention to attempt this or to make any invidious comparisons between methods or between hospitals.

It proposes to divide all hospitals into two classes, those which are satisfactory and those which are not;—and the basis for this classification is to be certain general principles in the conduct of a surgical service that are easily and

accurately arrived at, and are generally applicable to all hospitals, large and small alike.

To be regarded as satisfactory a hospital must meet certain minimum requirements. These are briefly: first, that the staff, whether closed or open, shall be organized and shall meet regularly, at least once a month. At these meetings, in addition to matters of general interest relating to the conduct of the service, the clinical experience of the staff shall be reviewed and analysed, "the clinical records of patients, free and pay, to be the basis of such review and analysis."

Second, "Accurate and complete case records be written for all patients, including the personal history, a physical examination with clinical pathology and x-ray findings when indicated, the working diagnosis, treatment, progress, condition on discharge, with final diagnosis, and in case of death, autopsy findings when available." And third, "that clinical laboratory facilities be available for the study, diagnosis, and treatment of patients."

Now, these are certainly not unreasonable requirements. I think every one of us would be willing to accept them as an irreducible minimum; and yet of 617 hospitals in the United States of 100 beds or more, only 190, or less than one-third, qualified as satisfactory under these requirements in 1919.

When the survey is extended to include hospitals of less than 100 beds, I am afraid conditions will be found much worse. Few of the smaller hospitals with which I am familiar, keep accurate records, and many keep no records at all.

Now, if we are going to maintain the position of the hospital as the most desirable place for the sick and injured, and are to expect a hearty response to our appeals for funds, it is certainly up to us to do our own house cleaning if we don't want to be forced to do it by outside pressure.

I am confident that a survey of the hospitals represented by the members of this Association would disclose few that were not doing much more than is required in these three propositions; but I think that we ought not to be content with that,—that as a matter of public duty we should try to make all the hospitals within our sphere of influence comply with these simple requirements. They can all organize and they can all have proper records, and they ought to. If they cannot have laboratory facilities of their own, they can at least have the assistance of some outside laboratory in having required tests made and reports rendered.

We can, as an Association and as individuals, render a real service to the community if we will but take an interest in this work and make a real effort to help it along. Our example is often worth much more than we think,—the active support of such leaders of the New England profession as are included in this Association would give it a tremendous impetus. It is one of the things that we can do to maintain the reputation of our New England institutions.

Personally, I wish we might go a little further. I believe the New England profession and the New England public would support us in asking a little more than this minimum standard. Much of the paper work required of the Chief of the Surgical Service in an army hospital seemed to be of little or no value to anybody, and there was much apparently unnecessary duplication of reports.

But there were some reports which certainly contributed much to the efficiency and good conduct of the service, and which I think might easily and profitably be employed in our civil hospitals.

In the first place there was the regular monthly report to the Surgeon General's office which had to contain the number of patients admitted and discharged, and the number of operations; the number of deaths, a brief résumé of the hospital record in each fatal case with the result of the autopsy; if the death was from appendicitis, in addition there was required the length of time elapsing between onset of symptoms and admission, and between admission and time of operation, and finally, the number of clean wounds becoming infected, in each case the type of operation, names of operator and assistants, and the type of organism.

Anyone who is in the habit of measuring his results by his impressions will often be very unpleasantly surprised when he has to put them down in exact figures.

This report was of tremendous help to me in determining the qualifications of my assistants, and in holding them to a stricter accountability for the character of their work. Then there was the occasional report on the commoner operations, such as hernia, appendicitis and empyema, —the type of operation done, the results; and most important of all, the length of time be-

tween admission and operation, and between operation and final discharge.

If the patient was in the hospital too long before a diagnosis was made or much longer than the average period required for convalescence, it was obvious that his time and the hospital's money were being wasted, or that the best methods of diagnosis and treatment were not being availed of. Such reports afford a simple and pretty accurate means of determining the character of the work done on a surgical service, and they are as important in a civil as in a military hospital. I would have them incorporated in the blank form proposed by the American College of Surgeons for the monthly *Analysis of the Hospital Service*, and I wish further that this analysis thus amended might be made a part of the minimum requirements for preferred classification.

It should be presented first to a meeting of the staff and then submitted at regular intervals to the trustees of the institution with such comments as the staff may choose to supply. Its submission to the trustees is, I think, particularly important, because after all the ultimate responsibility for the character of the service rendered by a hospital rests upon them, and from my observation in very few instances have they any knowledge or means of acquiring knowledge of what the staff are doing.

In a survey of the hospitals of Massachusetts undertaken a few years ago by a committee of the State Medical Society we found that in not a single one was there any real check upon the character of the work done by the staff.. This seems to me unfair to the patients in the first place, to the contributors to the hospital funds, and to the staff itself. The patients have a right to demand the very best service that the community can afford; the donors of funds a right to know that the best possible use is made of their money, and every member of the staff who is doing good work himself would certainly welcome it, because he is especially interested in seeing that the reputation of his hospital does not suffer from the careless or indifferent work of anybody else.

The different factors in hospital organization have never been brought into close enough contact. Each seems to be working independently by itself trustees, executive and staff, all without that coöperative effort which is as vitally necessary to secure the best results in a hospital as it is in a business corporation.

Such reports as I have thus outlined would give them a point of contact that could not help adding to the efficiency of all. Can we not bring a larger percentage of our New England hospitals than prevails in any other section of the country up to this higher standard?

I have thus tried to recall to your attention the splendid traditions which we have inherited from our fathers and the obligation imposed upon us to maintain them and hand them unbroken to those who shall come after us.

I have referred to a line of work in which I believe we can just now be exceedingly useful. I know that the scientific contributions of the Society will be important and of far reaching influence. If we will but devote ourselves unreservedly and unselfishly to the improvement of that public service for which the community holds us responsible, I believe the success and the permanence of this New England Surgical Association will be assured, and that we shall have good reason to be proud that we were permitted to participate in its organization.

Original Article.

SLIDING HERNIA.

BY EDWARD H. RISLEY, M.D., F.A.C.S., WATERVILLE, MAINE.

IT not infrequently happens that the surgeon finds himself unexpectedly confronted with a rare surgical condition the refinements of technic in regard to which he is not entirely familiar, and the solution of the problem is not always accomplished to his entire satisfaction.

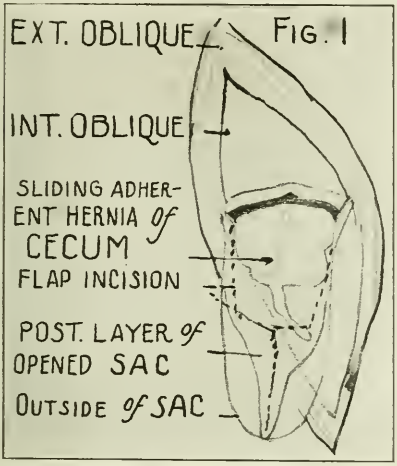
Such an experience is often presented by the condition known as sliding hernia; the exact anatomy and pathology of which are not generally clearly understood and the operative difficulties in effecting a radical cure may be considerable.

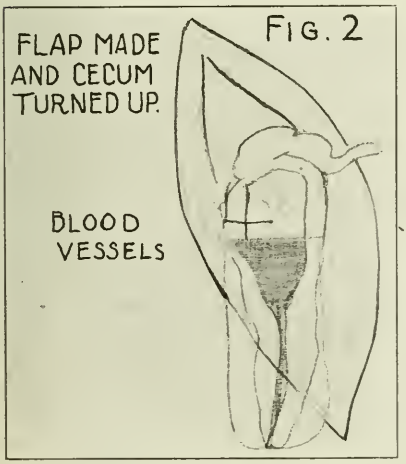
It is after an experience of this kind and with the hope of making this subject perhaps a little more definite and clear that this paper is presented.

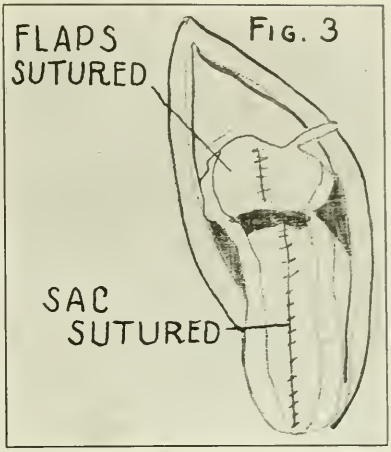
Incidence. The condition was described as early as 1806. In 2,200 cases of hernia at the Hospital for Ruptured and Crippled this condition was discovered in only 36 cases. Moynihan states that it probably occurs in about one per cent. of inguinal herniae. These figures agree approximately with those of other collected series.

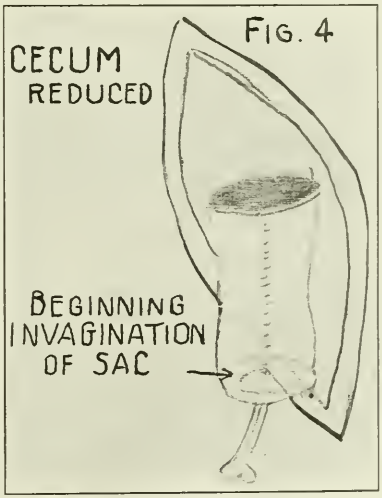
Pathological Anatomy. This part of the subject is the least clearly written upon and hence very indifferently understood by most surgeons. Hernia *par glissment* of the French, or "landslip of the colon" (cecum or sigmoid) of Treeves may be found at either the inguinal or femoral openings. It may occur both in children, where it is generally congenital, or in adults, where it may be either congenital or acquired.

It will be remembered that the peritoneum not only lines the cavity of the abdomen but envelopes most of the hollow organs, forming









back of them the mesentery which conveys their nutritional supply and gives them partial support. In the case of the cecum, the sigmoid, and the bladder, the covering is only partial. The sigmoid flexure is covered in front and on both sides but a portion of the back part of the bowel is in direct contact with the posterior wall of the pelvis (iliac fossa). The same may be true of the cecum. When hernia occurs to this part of the bowel it is the posterior (aperitoneal) wall that usually preecdes into the hernial opening, the peritoneally covered part

of the intestine, and hence, the most prominent or presenting part of the tumor is that part which is devoid of peritoneal covering. In other words, a sliding hernia of the ascending colon (cecum) or descending colon (lower sigmoid) or bladder at times, is one in which these organs with their posterior peritoneal attachments have become displaced from their usual location and a portion of the colon with its attached peritoneum gradually slides or prolapses downward into the hernial opening so as to finally form an integral part of the posterior wall of the sac. See diagrams.

Various degrees of slipping may be present, from very slight to a complete landslip of the whole iliac fossa. The above is the probable pathology in the majority of cases.

According to Keen, on the other hand, there may be no abnormality of the cecum and no preformed or congenital pouch of peritoneum in the canal (two conditions which, however, are usually present), but the cecum or sigmoid, occupies an abnormally low position, the peritoneum surrounding it only on its anterior and lateral surfaces while posteriorly it is loosely attached by connective tissue which permits the entire organ (cecum or sigmoid) to be gradually forced downward into the canal. Keen also believes that intraabdominal pressure due to straining, lifting, or coughing, which so frequently is the cause of the ordinary type of inguinal hernia, plays but a minor rôle in the production of sliding hernia. It is rather a regular, constant pressure, or pull, of over-distended colon which gradually forces or pulls the cecum or sigmoid to a lower and lower position until it finally is engaged in the hernial canal. In such cases the hernia can never be fully reduced nor can it be properly held by a truss.

It is claimed by some writers that a sacless variety exists but Treeves absolutely denies that any such condition can occur without some form of sac.

Ransohoff presents an entirely different etiology. He states that the condition is not due to sliding of the gut and posterior layer of peritoneum, but that at first there is a complete sac, that the gut has become bound down by secondary adhesions, and upon the amount of these adhesions depends the size of the future sac and, if excessive, the sac may be entirely obliterated. Walton and others disagree with this theory because it does not explain the presence of the bladder in a hernia and also it is never possible to demonstrate a layer of sac behind the adherent colon in dissecting these herniae.

When we state the following in regard to uncomplicated sliding herniae we have stated the pathology as simply and clearly as possible. A sliding hernia of the cecum or sigmoid is one the posterior wall of whose sac is made up of that portion of the colon which is generally devoid of peritoneum.

Hence, if the operator does not anticipate this condition and opens low down on the tumor he may find that he has made an incision directly into the large bowel through its posterior aperitoneal wall (See Fig. 4). If, however, he be so fortunate as to open high up on its anterior surface he will then have opened into the upper part of the sac which is in communication with the peritoneal cavity, will be able to recognize the true condition and thus avoid an embarrassing situation.

It is undoubtedly true that the congenital form of sliding hernia is produced by the same agent that helps the descent of the testis, for the gubernaculum testis is included in the same duplication of the peritoneum that contains the cecum and hence the bowel from this action is often drawn down in the wake of the testis. A similar condition results more rarely on the left side involving the sigmoid.

We find, therefore, that if a sigmoid or cecal hernia is reducible it means that it has a particularly complete sac and probably a long meson, and hence is not a sliding hernia in the strictest sense of the word.

A real slipping hernia also involves the ascending or descending colon as well as the cecum or sigmoid. This is of necessity so because of the landslide of the posterior parietal peritoneum of either iliac fossa, which displacement affects also the peritoneum higher up along the posterior abdominal wall.

Rockey is therefore right when he states that the descending colon and sigmoid as sliding herniae can occur only on the left and the ascending colon and cecum as sliding herniae can occur only on the right. The cecum may, however, present in the canal of a left-sided hernial opening, but in this case it is due to an elongated meso-cecum and is not a true sliding hernia. The same is true of the sigmoid

which presents (very rarely) at a right opening.

Symptoms. There may be none, even when the tumor is of large size. There may, however, be all degrees of constipation, often becoming so obstinate as to amount almost to obstruction, especially when the sigmoid is involved. Pain is not a characteristic feature, because torsion or strangulation is rare, owing to the large size of the neck and sac. Pain, however, is a constant symptom when the bladder is involved or when adhesions occur. Inability to completely empty the bladder and vesicle tenesmus are common in bladder herniae.

Diagnosis. This condition is oftener not diagnosed than it is diagnosed before operation. It is often not even possible to recognize the condition before operation. Especial points in diagnosis are the following: It will generally be noted that no matter what size the tumor may be, its neck is extremely large in proportion. Slowness of reduction is another feature which should lead one to suspect either cecal or sigmoid hernia, both of which are also generally direct in type. The usual gurgle which accompanies the slipping back of the ordinary hernia is absent; probably owing to the large size of the neck sac. Reduction is never complete and this is easily understood when we remember the pathology. Attempts at reduction are generally very painful. There is one other important indication which may tell us before operation what we are likely to find and that is the fact that the patient with this form of hernia can seldom tolerate the pressure of a truss. The reason for this is also evident when we consider the character of the sac contents. When one takes into account the large size of the neck of the sac, one is considerably surprised at his inability to reduce the hernia easily, and this fact alone should make one suspicious of the type of hernia with which he is dealing. This largeness of the neck of the sac accounts also for the rarity of strangulation in this kind of hernia. The presence of a large amount of gas in the tumor should put one on his guard against cecal or sigmoid hernia.

Operative Treatment. As previously mentioned, in speaking of the pathology, it is wise to remember that when one suspects sliding hernia he should open the sac as high up as possible in order both to be able to get into the peritoneal cavity at all and also to avoid cutting into the intestinal wall, which may form a portion of the lower part of the sac. Do not attempt to dissect the sac free from the colon, as this is practically impossible to do, and much injury to the blood supply may result. Avoidance of any injury to the nutrition of the gut is of greatest importance in these cases.

Bull and Coley reported relapses in one out of eight cases operated and other operators admit to an even higher percentage of recurrences. The reasons for poor success are evidently threefold.

1. The condition is a rare one and when suddenly and unexpectedly encountered by the average operator he is forced to repair the hernia as best he can without previously having had the opportunity to familiarize himself with the refinements in technic needed to overcome the difficulties in this particularly puzzling type of case.

2. Each case has its own individual peculiarities and so much variation occurs in these herniae that no single method of dealing with them can be advocated as being superior to any other, but the surgeon must be guided in making his choice of operative procedure by his own experience and the particular problem presented by the individual case. This statement holds true of the majority of cases.

3. The condition is one which *per se* is difficult to restore to normal because of the peculiar nature of the pathology involved.

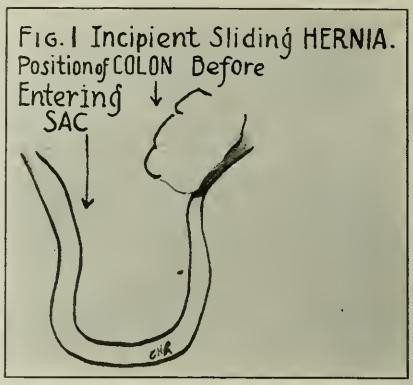
Fiaschi has had considerable experience with sliding herniae and considers relapse largely due to the inherent vicious habit of sliding down acquired by that portion of the intestine and peritoneum which forms the sliding hernia. In order to counteract the above tendency he supplements the ordinary operation on the hernia by anchoring the offending portion of the colon to the belly wall (colopexy) through a muscle splitting incision. This applies especially to hernia of the sigmoid and is probably the most efficient method of permanently curing these difficult cases. To this procedure should probably be added castration to obviate further drag and to make closure of the sac more complete. (The author in one case of irreducible sliding hernia of the bladder in which it was impossible to separate the bladder from the sac and in which permission to sacrifice the testicle was lacking, invaginated the bladder, testicle

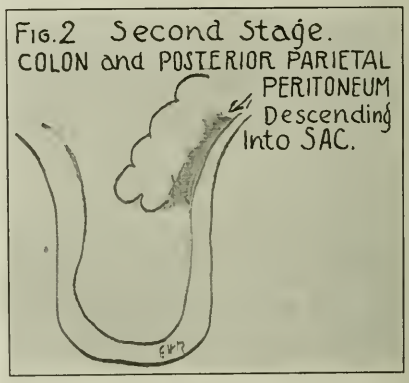
and cord through the inguinal ring and effected a permanent radical cure of the hernia, the patient having no discomfort from his abdominally housed testicle). Practically all pseudo-sliding hernia or those with a freely movable cecum or sigmoid, which presents at either right or left hernial openings can be cured by simple replacement, high ligation of the sac (for they are free and have a complete sac and hence can be easily and entirely replaced into the abdominal cavity) and radical cure by the usual methods.

But the true sliding hernia is a much more complicated problem and is probably best dealt with by using some modification of Weir's flap method; it being paramount to avoid constriction of the bowel and injury to the blood supply and also to effect a complete reduction of the bowel in order to prevent relapse.

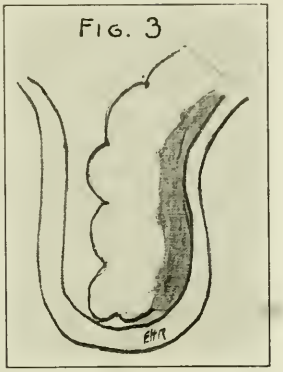
Various modifications of the flap method will be found necessary in different cases. Suffice it to say that this is generally the method of choice because it is practically the only method which avoids injury to the blood supply of the bowel and avoids constriction. This method is applicable in most all irreducible herniae and those otherwise suspected of being of the sliding variety. The various steps are as follows: Expose the sac and free completely from surrounding structures and cord. (This is not always easy but should be accomplished if reasonable care is used.) Open sac at its highest anterior point. Enlarge opening along anterior surface of sac so that its contents are freely visible in their entirety. Divide sac on posterior aspect to within one half inch of the caput coli, then carry incision along either side of the colon as far as the neck of the sac and one half inch from the lateral wall of the colon. Pull colon upward. Two flaps of the peritoneum with blood supply intact are formed. Suture these together so as to cover the bare posterior surface of the colon. Suture the two edges of the divided sac behind the colon which renders this latter now entirely reducible. The sac being now restored can either be invaginated by Kocher's method of pushing it up beneath the fascia and transfixing or it may be partially excised. See diagram.

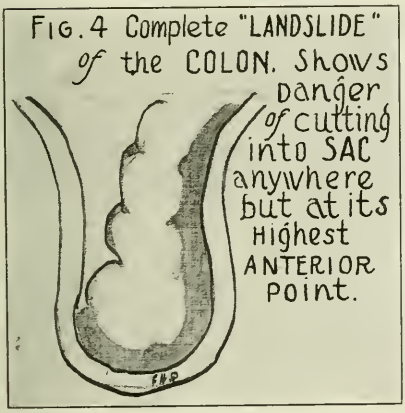
Hotchkiss in order to deal successfully with certain less marked types in which the flap method is not necessary but the colon is nevertheless irreducible, constructs an elongated meso-colon from the tissue of the hernial sac





wall in such a manner as to permit of the easy and perfect reduction of the gut into the abdominal cavity and not to interfere with the suture of the internal opening of the sac. The steps of this procedure, which is really a modified flap method, are as follows: Free the sac from the cord, open the sac anteriorly, incise upward on sac to internal opening and downward to nearly the lowermost point of attachment of the meso-colon on the posterior wall, which permits easy eversion of the sac wall. Grasp the adherent colon, pull gently forward and it will be found that the peritoneum of the split hernial sac will become everted in such a manner as easily to form a new and elongated mesentery of the colon with its smooth peritoneal surface turned outward to form its free surface and its other non-peritoneal surfaces falling in contact. Suturing the edges of the new mesentery together permits its elongation





to an extent sufficient to allow the perfect reduction of the colon into the abdominal cavity. The hernia is then repaired in the usual manner.

In order to further strengthen the repair the transplantation of the rectus sheath is often advisable and this procedure is used as a routine by many.

With the distinctly adherent type the condition is often more puzzling, the opening into the peritoneal cavity often extremely difficult to find, injury to the blood supply a definite danger, and a great slowing up of operative speed results. The thing here to be remembered is that the highest possible opening of the sac will generally let one safely into the general abdominal cavity and when once in, one's landmarks can be the more easily determined and the operative repair hastened.

If the surgeon will always suspect the sliding type of hernia when he finds one in which a truss is poorly borne, in which complete reduction is not possible in spite of the large size of the sac neck, or in which there is no gurgle, and always opens the sac high on the anterior surface, he will save himself much operative embarrassment and will put himself in a proper position to deal successfully with a decidedly difficult condition.

The problems encountered in the author's case were difficult to solve at first.

The patient, a man of 60, in only fair general condition, due to chronic nephritis and a low grade prostatic obstruction, had had a large irreducible tumor of the left inguinal region and scrotum for a number of years. A properly fitting truss was uncomfortable, but a loosely fitting truss gave some support, but did not completely hold his hernia. He had never had much pain until the day before he was seen, when the pain became sharp and constant, his bowels could not be moved and he felt nauseated, but did not vomit. Physical examination showed a large, soft, rather "boggy" left scrotal tumor which could be only partly reduced. Attempts at reduction caused much pain and there was marked local tenderness. A diagnosis of incarcerated and possible strangulated hernia was made, immediate operation advised and accepted. Local anesthesia was used, because of the patient's general condition. The sac was fortunately opened high and a loop of very dark colored but not entirely lusterless small intestine first presented. Below this was found a very much adherent sigmoid and a condition of strangulated hernia of the small intestine complicated by sliding hernia of the sigmoid recognized. The condition of the small intestine was very doubtful. The neck of the sac was cut and stretched, and the doubtful small intestine delivered onto the abdominal wall and surrounded by hot packs while the adherent sigmoid was being freed. This was fortunately accomplished completely enough so that the sigmoid could be reduced entirely without doing a complete flap operation. A small raw "V" shaped surface was left, however, at the lowermost part of the sigmoid loop. By the time the sigmoid was reduced the luster had returned to the small bowel; it was returned to the abdominal cavity and a radical cure done. Eighteen months have elapsed now without recurrence of discomfort. This was an

atypical operation which probably would better have been done by the flap method with which the author at the time was not entirely familiar, but the result has been satisfactory.

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Clinical Department.

TORSION OF THE FALLOPIAN TUBE.

BY SAM S. DEARBORN, M.D., F.A.C.S., NASHUA, N. H.

THE following case may be of interest because of its comparative rarity.

Mrs. C., aged 50, married twice, no children, no miscarriages. A vigorous, active woman.

Previous history: Nothing unusual except at intervals of a few weeks or months moderate pains in lumbar region and both sides of pelvis lasting for a short time with complete absence in the intervals. Appetite, digestion, and bowels normal. Catamenia every three and a half to four weeks. Five years ago, excessive in amount; of late years normal, both as regards pain and amount of flow. Slight leucorrhoea.

September 8, after working in her garden, which necessitated stooping over, was taken with rather severe pain in right loin. Examination revealed marked tenderness in region of right kidney, the lower portion of which was palpable and freely movable. Pulse, temp. and urine normal.

September 9. Pain now in the region of McBurney's point and tenderness over the same area. No spasm, distention or rigidity. Vaginal examination showed an apparently normal uterus. Slight feeling of indefinite resistance in both fornices. Pulse and temp. normal.

September 10. Pain at intervals, not constant, but more severe through whole lower abdomen. Tender over both Morris' and McBurney's points. Increased resistance to abdominal palpation, although no absolute rigidity of the recti: moderate distention. Nurse reports a slight "show" of blood from the vagina during previous night. Vaginal examination revealed a tender mass behind cervix. Both fornices less tender but somewhat resistant. Examination not very satisfactory because of fat abdominal wall, distention and general tenderness. Pulse, 90; temp., 100.6. Bowels have moved freely. No nausea or vomiting.

Diagnosis: Probably appendicitis with salpingitis and less probable, extrauterine pregnancy. Operation advised and accepted.

The right tube was found to be enlarged to twice its normal size, twisted once and a half on itself, black as gangrenous intestine: the fimbriated end lying behind the uterus just above the junction with the cervix: the right ovary was the size of a plum, somewhat darker than normal, and contained several small cysts. The left tube was enlarged to three times its normal size, slightly injected in appearance and filled with a pale, straw colored fluid. The appendix was enlarged, convoluted, its vessels deeply injected, and it contained a concretion in the tip. Tubes, ovaries and appendix removed. Uterus was allowed to remain because of the patient's condition. Convalescence uneventful.

Society Report.

PROCEEDINGS OF THE NEW ENGLAND BRANCH OF THE AMERICAN UROLOGICAL ASSOCIATION, MAY 19, 1920

THE New England Branch of the American Urological Association met in the parlors of the Hope Club, Providence, Wednesday, May 19, 1920, at 8.35 P.M. Dr. O'Neil presided. After the regular routine business, patients were presented and discussions were had as follows:

DR. GEO. A. MATTESON: This case is one of hypernephroma presenting several unusual features, of which the most interesting are: first, that the secondary metastatic development in the right iliac bone preceded the recognition of renal tumor or any urinary symptoms; and, second, the high degree of arterial vascularity, giving the tumor the characteristic of aneurism, namely, marked expansile pulsation and a loud systolic bruit.

The first diagnosis was aneurism. Of course we appreciated that there was scarcely a vessel in that vicinity which would be large enough to develop an aneurism of that size, but it wasn't so far from the superior gluteal artery, and we felt it might possibly be that. In our ignorance we attempted to remove the tumor and found it very difficult indeed, and cut into such a hemorrhage that the removal was very incomplete.

Our pathologist reported that the tumor was a chordoma. I believe only 17 cases have been reported. That was the diagnosis which stood until we sent the man to the Huntington Hospital, Boston, for some radium treatment. Another specimen was taken and a tumor in the kidney region had developed, which up to that time had not shown, there being at no time any urinary symptoms. This specimen was reported by Dr. Wright as hypernephroma.

The patient, since that time, has had six treatments with radium at the hospital at Boston, but his general condition is still going down. It may not be new to others of you more experienced than I in this line of work to find that his tumor is so pulsating.

The patient is presented. A man of 45, emaciated and cachectic, having in the right sacroiliac region, a diffuse tumor about eight inches in diameter which pulsates visibly. At the summit of the swelling is a fungoid mass of necrotic tissue projecting from a sinus one inch in diameter in the middle of an operation scar. The sinus extends down to an erosion perforation in the wing of the ilium, as shown by radiograph. There is also a palpable mass in the area of the right kidney—in which pulsation can *not* be demonstrated.

Dr. Matteson also placed on exhibition a radiograph print and a stone taken from the kidney, interesting on account of its size, it being a spherical phosphatic calculus with a harder case, measuring 2⅛ x 2⅜ inches in its two principal diameters. The kidney had been reduced to a shell almost without functional value and was removed.

Dr. Arthur T. Jones: I had a man sent to me with idiopathic gangrene of the scrotum.

The following history: Saw him February 14th, this year. Previous history negative. No venereal history. A few days previously he had complained of pain in the testicles. He went to a doctor in the neighboring city of Pawtucket, who applied an ichthyol ointment, 25%. When he came into the hospital his scrotum was four times normal size, gray and oozing, and on the verge of sloughing. We made incisions in the hope of saving it, but it was pretty well degenerated. About five days later his entire scrotum sloughed off, leaving the testicles bare. It came off around the base, as if some strong irritant had been applied; also a ring around the penis that was denuded and sloughed, and another area near the glans penis. This was superficial and under treatment of plenty of peroxide healed nicely. It was a question of whether to castrate or make a new scrotum. We decided to cover the two testicles, which we did on March 19. We lifted a portion of skin from each thigh and shoved those flaps over and united them in the center, leaving an area on either thigh for skin grafting. This area contracted down so he didn't have to be skin grafted. The third of April he was discharged as well.

Since then, on May 6, I saw another case. No venereal trouble or injury of any kind. In this case, a small scratch appeared on the prepuce. He said he got it from a pin in his drawers. He denied absolutely that there was any possible venereal disease. I think he was perfectly honest. In view of the other case that I had had, I suggested that he probably would have sloughing of his scrotum. This did occur, and the anterior surface of scrotum sloughed away. The entire skin of the penis has sloughed clear to the very base. His general condition is good and he is coming along all right and will evidently have enough scrotum to stretch over and cover the testicles. I would be very glad to show the result if you wish. (Patient is produced. First case reported.)

I undermined the edges and slid them over and united the edges in the center, using a mattress suture, after making a curved incision on the inner aspect of both thighs, dissecting the outer edges of the flaps free. The outer edges were caught down with a few sutures to the fascia to keep the testicles from slipping out from beneath the flaps. Both testicles are in one sac.

RUPTURE OF THE RENAL ARTERY.

Dr. Cook: The case presented considerable difficulty and was seen by several doctors. The man was sixty-four years old, apparently in perfect health. He was taken suddenly with a fainting spell and fell. This was not regarded as serious. The family doctor was called and he said he was all right. On the third day he developed a very severe pain in the hypochondrium.

The pain was so severe he called in Dr. Cherry, who examined the man carefully and thought he had a gall-stone or abscess. It was after he was in a dying condition, and two days later, when a large mass which filled the left half of the abdomen became apparent. I was called in that afternoon and found this man practically pulseless, with this mass filling the left half of the abdomen. It felt like a large spleen. The man's blood pressure was 75 m.m.

We were fortunate in securing an autopsy.

We found a clot of blood situated behind the peritoneum about fifteen inches long, largest diameter perhaps five inches across. The intestine was stretched across this region. The autopsy was done at night and this mass was taken out. We discovered, the next day, the whole thing was hemorrhage, and the renal artery was found. I asked Dr. Cherry if that mass was present when he saw the man, and he said "No." So, evidently, this slow hemorrhage was going on for five days, finally resulting in death through hemorrhage.

REPORT OF A CASE OF INFECTIOUS ANEURYSM OF THE AORTA.

DR. W. C. QUINBY: Patient was a middle-aged woman of negative family history as well as of negative Wasermann reaction. For a year previous to entering the Peter Bent Brigham Hospital she had had evidence of a chronic infection: first, an acute condition in the right knee; then, a few months later, an otitis media, and then pain and lameness associated with the region of the left hip joint. She had been in two hospitals previously. On reaching us she showed a fever, leucocytosis, and definite abscess in the left flank, with fullness and redness. She was operated on by the resident physician, Dr. E. C. Cutler, and a perirenal abscess opened and about a pint of pus evacuated. On investigating the depth of the abscess cavity a soft area was found which showed pulsation synchronous with the radial pulse. No further effort was made to find the origin of what was apparently an aneurysmal sac. The wound was drained and the patient put to bed.

About a week later she had a sharp hemorrhage from the wound and it became manifest that the condition must be further investigated. On the assumption that the aneurysm was of the renal artery I made a median incision high in the abdomen, intending to ligate the renal artery at its junction with the aorta. In the meantime the patient was transfused. On reaching the anterior surface of the aorta, however, it was found that the aneurysm was of this vessel itself and not of the renal artery. I therefore closed the abdomen. About ten days later, the patient had a second severe hemorrhage which proved fatal.

At autopsy it was found that the primary cause of the trouble was a psoas abscess which, having existed over a sufficient length of time, had eroded the lateral and posterior wall of the aorta which had become infected. In other words, the aneurysm was of the true infectious type and was in no sense due to disease primary in the vascular wall.

DR. E. B. SMITH: I will report briefly a case of transposed viscera which I discovered at the operating table a few days ago. This case is interesting to me because of its rarity, in my experience, and also on account of mistaken diagnosis on my part.

A woman of 62, rather stout, had been complaining of abdominal pain with some nausea and vomiting for two years. Increasing constipation, never amounting to obstipation, however. Patient had lost weight steadily for a year. Upon casual examination of the heart, the sounds seemed rather distant but appeared to be normal. Urine showed no blood or pus. A very large, slightly movable tumor was found in the left side extending from the costal border to the crest of the ileum. It seemed incredible to me that there could be an intestinal tumor of that size on the left side without obstruction. I believed it was hypernephroma and made an incision through the left rectus with a view to removal if possible. It was then that I discovered that the viscera were transposed and the growth was cancer of the cecum.

DR. KEEFE: A girl, 11 years of age, was brought to us for treatments for enuresis, or bed wetting. The history is as follows: Father and mother living and well. No history of T.B. or cancer in the family. The patient had her tonsils and adenoids removed two years ago. Eyes—pupils equal and react to light and accommodation. Teeth—in good condition. Tongue—clean and moist. Throat—clear. Lungs—resonant throughout, tactile and vocal fremitus normal. Heart—normal in size and rhythm, no murmurs present. Abdomen—soft and tympanitic throughout. Reflexes—active. Extremities—normal. January 30, 1920, sp. Gr. 1010. Sugar—none. Albumin—slightest possible trace. Reaction—acid. Large number of squamous bladder cells and a number of pus cells.

She now attends a boarding school where those about her have found the continual bed wetting very annoying, as well as the frequent desire to micturate during school hours; also the incontinence of urine during the day.

In this case, the enuresis has existed since infancy. The bed wetting occurs three or four times during the night, with occasional incontinence during the day. She has been treated by a number of physicians with medicine, but her distressing condition remains unimproved.

Her home surroundings are exceptionally good; she is the picture of health, strong and well developed. Her mother has again and again tried to impress upon her the necessity of gaining control of the vesical sphincter. At times she has offered her rewards to induce her to make an effort to control the incontinence, and again she has punished her by taking away certain privileges; but all her efforts have proved to be unavailing.

The child, who is the only girl in the family, has been pampered and petted since she was born. She speaks with a lisp and very little has been done to correct this defect; on the con-

trary, admiring relatives and friends induce her to speak in order that they might hear and approve of this lisp, it sounds so cunning. Mentally, the child is not as far advanced as other children of her age.

I believe that the lack of control of the vesical sphincter is also due to the difficulty of creating enduring mental impressions in the brain.

February 13, 1920. Ether—cystoscopy. Bladder—normal, with the exception of congested and dilated blood vessels at the vesical outlet. The urethra was dilated to allow the introduction of the cystoscope. The night following the dilatation method there was no bed wetting. However, about five days later she again wet the bed.

Ether was again administered March 2 and March 9 and sounds were passed into the bladder—numbers eighteen to twenty-eight, French scale. A 10% argyrol solution was injected into the bladder with irrigations of boric acid twice a week.

[NOTE—May 18, she has wet the bed but once during the last three weeks, and has complete control during the daytime.]

Enuresis or bed wetting is a condition found among rich and poor, healthy and unhealthy children.. It is a persistence of an infantile habit, which in the normal child is controlled about the third year. Control of the vesical sphincter lies in nerve centers in the lumbosacral cord and in the brain. Numerous causes of enuresis have been put forth by writers on this subject: malformations, phimosis or adhesions around the clitoris; yet we find circumcision has failed to cure in a large percentage of cases; partial asphyxia during sleep from adenoid vegetations: pin-worms; deficiency of thyroid secretion; neuro-muscular fatigue.

I doubt if any one of the cases above mentioned exercises any appreciable influence on this condition. I believe that mental retardation is the most potent cause of enuresis. The condition appears to have no relation to mal-nutrition, but to be dependent upon the lack of lasting impressions made upon the brain cells. A sufficiently definite impression upon the brain cells must be made during waking hours, which impression must last during sleep, in order to prevent relaxation of the vesical sphincter muscle.

We are all familiar with the fact that many persons before going to sleep are able to make so deep an impression in their brain cells that they are able to awake in the morning at any hour they desire. Where we have many causes assigned to a disease, we have variety in the methods of treatment.

In the treatment of these cases, judicious management is essential. The patient should be helped, encouraged, and taught to have self-confidence. Suggestion has an important bearing. Complete change of environment, and even removal to a hospital may be necessary in certain cases, when the home influences may be at fault.

A regular and plain diet with sufficient time for rest is desirable. The child should not be given fluids for two hours before retiring and may be awakened several times during the night to anticipate the involuntary by a voluntary emptying of the bladder. The passage of sounds into the bladder has been effective in many instances.

Belladonna, strychnia, and thyroid extract have their advocates. During the late war, many distressing cases were found among the soldiers and sailors and some were benefited and others cured by the use of electricity.

A number of cases have been treated by lumbar puncture. Following the withdrawal of 10 c.c. of the spinal fluid an equal quantity of physiological salt solution has been injected into the spinal canal, with the results that many patients have been cured, even those of long standing, in adults.

To sum up, I believe that the principal cause of enuresis is a mental retardation.

QUESTION BY MEMBER: Did this child have a residual?

DR. KEEFE: No.

QUESTION: You say she did have pus in the urine?

DR. KEEFE: At the beginning; but after the treatment of boric arid irrigations that entirely disappeared.

QUESTION: How do you account for pus in the urine?

DR. KEEFE: I don't know just the cause.

DR. W. D. BIEBERBACH: A man about 25 years old, came to me on account of frequency at night. He was not annoyed during the daytime, but would urinate seven or eight times during the night. On examination I found that the urine in the three-glass test was clear and sparkling, no evidence of pus. The bladder wall was normal, but the trigone intensely reddened and the inflammation extended to the posterior urethra.

I catheterized both kidneys and the pig was inoculated. The right kidney pig lived about six weeks and on post-mortem was negative. The left kidney pig died at three weeks with a colon bacillus infection of the peritoneum.

I have started the patient under treatment by irrigating the sick kidney with silver nitrate solution. While he has been treated only twice, his frequency is down to about twice at night.

BY A MEMBER: It is rather hard for me to see Dr. Keefe's explanation of mental retardation when asleep. It would seem to be a part of automatic control. I fail to see how it applies at night if the patient sleeps. Furthermore, it does not balance up with the situation we know rather vaguely about. You have an automatic bladder which is entirely cut off from the central nervous system, at least the cerebrum. That bladder will hold water up to a certain point of distention. Scratching the thigh or stroking the abdomen will cause that to empty itself. That apparently is the condition which attains when the bladder is free from any control whatever by the cerebrum.

DR. KEEFE: Of course, we know there are reflexes in the spinal cord, and whether we have educated the spinal cord from our brain originally we can sever the cord and the cut contracts the muscles. I cited that instance that shows that at night, while we are asleep, we do control definite things that produce our awakening at a certain time; that shows that our mind in a subconscious state does work while we are asleep; so is my feeling with regard to these patients. Though you can't cut the cord, some bladder control is due to the education of the centers in the cord. Besides, I feel that as the brain is defective, these impressions are not sufficiently definite in the brain cells. For instance, this patient may not remember and forget things more readily than a child whose mind may be more easily impressed. So, it would seem to me that we do have a subconscious working of our brain during our sleeping hours, and I am inclined to think that dilatation near the neck of the bladder may be sufficient to set up some impression in the brain and thereby help the brain ultimately control the bladder.

Because this patient had done it so many years, just the delight at not doing it during these five days (something which had never happened before) was sufficient to awaken and coördinate the necessary impressions. Some cases in the Army were treated by electricity and my feeling is that besides using the electricity an impression is made on the individual and brings to his consciousness the fact, and thereby awakens a subconsciousness in his brain which acts during his sleep.

DR. DONLEY: From the viewpoint of a neurologist, Dr. Keefe's paper is of much interest because it is obvious that although he is concerned with the symptomatology of one viscus, his vision sweeps a wider horizon. It is, of course, common knowledge that the bladder is affected functionally by a number of influences playing upon it, and that these influences, whatever they may be, mediate their effects through the nervous system. Hence, it is no mere hypothesis that the nerve control of the bladder is very important, and so it seems to me that the opinions set forth by Dr. Keefe are worthy of this serious consideration, if for no other reason than this, that they will help explain why we so often fail to relieve these patients by treatment directed to the bladder alone. And, again, they will perhaps shed some light on the problem as to why so many diverse treatments have similar successes to their credit. If the nervous factor is as important as Dr. Keefe thinks it is, then our therapeusis ought to take that fact into consideration.

I know this little patient of Dr. Keefe's very well and it has been really surprising to watch the way in which bladder control has been established in direct proportion to the improvement in her mentality. She was not feebleminded or backward in the usual sense, but she was, by reason of injudicious education in a distinctly childish mental condition. With the removal of her infantile mental fixations, her infantile bladder, if I may express it so, has shown a corresponding improvement, that is to say, she has substituted voluntary for merely reflex control of the organ. Whether, and in what way, we can reëducate these irritable bladders it is difficult to say, but it is surely of value to have our attention directed to the matter in a way Dr. Keefe has done it, and I, for one, am glad to learn that urologists are not infrequently neurologists as well.

DR. L'ESPERANCE: Dr. Keefe has mentioned the fact that this child was infantile along other lines and that has been a frequent observation on my part that this appearance is common with children suffering from enuresis. In the clinic we frequently ask the nerve specialist to grade these patients before treatment is recommended. We treat the normal child with the assistance of the mother and successful results depend greatly upon her faithfulness in carrying out home treatment.

In mentally defective children, from the low to the high grades, the results of treatment vary according to the grade of mentality. A certain amount of brains is necessary for reeducation of bladder function.

Yesterday a boy seventeen years of age came to the clinic: his appearance was not that of a very bright person. In the course of examination it was found, among other conditions, that this patient was now sleeping, and had always slept, on a feather bed. I believe that is a very common contributory cause of enuresis.

One of the most interesting patients I had very early in my medical practice was a young lady, who had reached the age of sixteen and gave a history of having always wet the bed during the night. In the presence of this young lady a uriniferous odor could be detected at all

times. This was very humiliating to herself and her family. This patient I treated only three times. The urine was clear and negative and a cystoscopic examination showed a normal bladder except that two ounces of fluid was all she could hold comfortably.

On the second visit, I gradually dilated to about six ounces, the third to ten ounces. This patient wet the bed only once after her first treatment and on that occasion after eating sour pickles and drinking much water before retiring. I know this young lady very well, also her family, and I have been informed by her mother that she has never wet the bed since her treatments, over ten years ago.

The fact that enuresis is caused by many different conditions eliminates the possibility of a cure with one kind of treatment.

Dr. E. G. Crabtree: I have to report a similar case to those already discussed which, I think, emphasizes the effect of fright occasioned by an operative procedure on a subnormal child in clearing up troublesome lack of urinary control. The child was six years old, the adopted son of a South American family. He had a subnormal mental condition with physical deformities consisting of a high arch of the hard palate with considerable attendant nasal obstruction and a partial row of double teeth, shown by x-ray; also a spina bifida. Urinary difficulty has been more pronounced in the South than since his return to America, and consisted of frequency and incontinence, with an occasional escape of urine at night. Most of his trouble was passing of the urine into his clothing during the day. His mother had taken great pains to attend to this condition by careful explanations, without success. The child apparently gave attention to his instructions, yet the condition was not influenced. On the possibility that we might be dealing with a diverticulum, congenital stricture or some other abnormality, ether cystoscopy was done. No deformity other than the spina bifida was found. The child resisted ether and in general had an uncomfortable experience. After recovery, he has shown complete control over himself in the day time, but there has been no change in the condition at night, and once or twice a week urine escapes from him in his sleep.

The explanation of this sudden change seems to me to be twofold. The child has been in much better general physical condition since coming to America, in a cooler climate, than he was in South America. The other thing which stands out as a part in the change is that the child links up his ether struggle as a sort of punishment for not controlling his urine by day. The experience has made a profound impression on his mind and seems to be the chief factor in accomplishing an improvement.

Dr. Bieberbach: A boy of 19 wet the bed at night. When the war broke out he was a member of a local military company and was sent across with the 26th Division. When he started across he noticed that his trouble at night disappeared. No wetting of the bed occurred while on the firing line or during his after service in the army. It is now almost two years following his discharge from the army and he states that he has had no return symptoms of his former trouble. At the present time he is married and apparently in good physical condition.

The President: During the war I was surprised to find the number of cases of enuresis. I had never known its prevalence in adult life. I thought it was confined entirely to children.

PROSTATECTOMY AT THE BOSTON CITY HOSPITAL.

Dr. H. H. Howard: When Dr. Thorndike and I went on service last fall, we were determined, if possible, to cut down the high mortality rate in cases of prostatic obstruction.

As you probably all know, cases which come to any municipal hospital are not cases which would be considered most favorable risks from any standpoint.

On carefully going over the previous records in these cases, it was rather interesting to find that a number of them were operated all in one stage and very few were done in the two-stage operation. The mortality in the one-stage operation is alarmingly high and in many cases which had been operated on in the two-stage operation, the mortality following the first-stage operation was also alarmingly high. Many of the cases were operated upon the day after admission and the majority within forty-eight hours after admission.

From the results of these cases we determined first, that the interval between the man's entrance to the hospital and his operation was altogether too short; second that in the cases where the first stage was done and followed by death, that something in the after-care was radically wrong, that the interval between the first and second stages was, in most cases, altogether too short, so that the following plan was adopted:

An ambulatory case coming into the hospital with prostatic obstruction, first had his 24-hour urine carefully gone over, together with his blood urea and phthalein test. If the blood urea was high the man was put on a restricted diet with forced fluids, some urinary antiseptic was given and rather active catharsis followed out. In the majority of these cases the blood urea came down within a week. During this time the man was not permitted to lie in bed, but was kept up and about and an endeavor was made to get him acquainted with the other patients in the ward and interested in games, and things other than his own general condition.

If the case was bedridden at the time of en-

trance and after examination no reason was found why he should not be permitted to get up, the patient was made to get up, at first for short intervals of time, and then gradually for the greater part of the day. Most of these bedridden cases were cases with high urea nitrogen and dirty bladders.

Cases that came in with over-distended bladders were treated with an indwelling catheter and frequent irrigations for a period of about a week before the first stage was attempted. Following the first stage, those cases in which the urine had been full of pus and the patients running a rather high urea nitrogen, in all these cases before they left the operating room, subpectorals of a thousand cc. salt solution were given and this was repeated every four hours thereafter if the patient showed any evidence of vomiting, headache, or any of the other symptoms of uremia from absorption.

All first-stage cases were gotten out of bed on an average, the fourth day after operation. The average length of time between the first and second stages in fifty-nine cases was a period of ten days; the maximum was four weeks. Between the first and second stages all the cases had a second urea nitrogen done and a second phthalein.

In the three fatal cases which were done in this series of operable cases, it is interesting to note that the urea nitrogen did not come down in all of the time lapsing between the first and second stages in spite of any kind of treatment. The phthalein test was used merely as a color index and nothing more, the most stress being placed on the urea nitrogen test.

All of the cases between the first and second stages had frequent bladder irrigations and the only solution used was hot boric salution.

Following the second stage, in almost every instance, the cases were given subpectoral salt solution of a thousand cc. before leaving the operating room and the house officers were instructed to give subpectorals in the ward at the first evidence of a developing uremia. They were gotten out of bed within practically the same time as the cases following the first stage and induced to get associated with the men in the ward who were up and about and also to get interested in games, and the old men who were weak and unable to get about without assistance, were led up and down the pavilion by other patients who were farther along in their convalescence. Dr. Thorndike and I both came to the conclusion that the spirit of good-fellowship and getting a man interested in something besides his own troubles, had a great deal to do with his convalescence.

In none of these cases was an indwelling catheter placed after the second stage, and the suprapubic drains were all removed on the fourth day. It is interesting to note that in these cases none developed an epididymitis; only where sounds were passed before the man started to urinate in the normal way did any case of epididymitis develop, and these were few and far between.

From the experience gained during this year we came to the conclusion that the urea nitrogen test is of inestimable value; that a great deal is gained by first getting the man accustomed to the hospital and hospital conditions, regulating his diet, and carefully studying the man as regards his whole general condition. We also came to the conclusion that in practically every instance where death followed the first stage it was usually due to lack of sufficient fluids. This also held true following the second stage. Thirdly, the less you do to the urethra the less the chances are of the case developing an epididymitis.

QUESTION BY A MEMBER: What is the limit of blood urea you think safe to operate?

DR. HOWARD: We have operated on one as high as thirty. Dr. Ohler rather thinks twenty-five is about the limit.

DR. CHUTE: I do not understand why Dr. Howard waits before giving preliminary operation.

DR. HOWARD: We wait for the simple reason that most of these old men when they come in, for the greater part, have a high blood urea, distended and dirty bladders—old fellows not accustomed to hospital life—and by getting them cleaned out and accustomed to their surroundings and allowing their blood ureas to come down, results are much better.

DR. CHUTE: I cannot see any advantage in not opening them up at once; you thus start them on the up grade at once, you relieve what causes retained urea; you have to watch the kidney reaction, but it seems to me that you waste just so many days in waiting.

DR. HOWARD: We have found in a definite number of cases that by waiting, the blood urea does come down without operative interference and at the time of operation they are much better surgical risks and stand the first stage with much less shock than those that are done within forty-eight hours after admission.

QUESTION BY MEMBER: If you drain suprapubically, why not take away the pressure early?

DR. HOWARD: In only the cases that come in with chronically and very much distended bladders do we use the indwelling catheter and we do that to prevent hemorrhage and severe shock which does follow this type of case in a great many instances.

QUESTION BY MEMBER: In how many cases have you used the catheter preliminary to cystotomy?

DR. HOWARD: In only about ten.

DR. E. G. CRABTREE: I feel that I should join the minority in this meeting in expressing ap-

proval of Dr. Howard's post-operative treatment in the drainage of prostatics. I have of late not used drainage of any kind except a suprapubic tube for a period of two days after the second step of prostatectomy has been completed. I have done this because I believe it to by a way out of prostatectomy without the peri-urethral abscess formation and epididymitis, two complications most common and trouble some in cases drained by indwelling catheters.

I have done fourteen cases by this method without the development of either peri-urethral abscess or epididymitis. The dates of closure of the wounds on the last eight cases are worth recording.

The best result which I have obtained was that of a man who continued to void at least two-thirds of his urine from his fifth day on. He voided the whole of his urine from his seventh day. One other case voided the whole of his urine from the eleventh day. One from the fourteenth and the remainder within three weeks. I believe a particular point in the operative technique aiming toward earlier closure of the wound where bladder drainage is not used is the use of a small suprapubic incision. I aim not to make the incision longer than two inches, some have been shorter than this. I recognize that in any cases where diverticulum or other complications exist so simple an operation is not feasible.

Question by a Member: Do you drain your cases through the indwelling catheter and sew the bladder up tight?

Dr. Crabtree: No, I leave no drainage in the bladder after a second stage except a suprapubic tube which is allowed to remain two days or a little longer in case there is oozing still continuing. The tube is then removed, sutures left in place and later, when the wound is well granulated, the edges are strapped across with adhesive. I have never had the courage to suture any bladder without drainage after doing a prostatectomy. Bleeding at the time of operation or delayed bleeding may come and produce a very uncomfortable situation.

A vote of thanks was extended to Dr. Keefe and the Providence members.

Meeting adjourned at 10.20 P.M.

Book Reviews.

Electrical Treatment. By Wilfred Harris, M.D., F.R.C.P. Third Edition. New York: William Wood and Company. 1920.

In order to include the new or modified methods of electrical treatment devised during the war, there has been prepared a third edition of this book, "Electrical Treatment." In its main outline and general purpose of presenting a comprehensive view of the various forms of electrical treatment as it is practised today, this edition is similar to previous editions. There have been minor alterations in the text, however, and some additions have been made. Particular attention is given to the work which can be done with faradic and galvanic batteries in the relief of such complaints as acute sciatica, brachial neuritis, and other forms of perineuritis. The theory of various forms of current are explained and methods are considered for the use of faradism, galvanism, sinusoidal and pulsating unidirectional currents, static electricity, high frequency currents, and diathermy. The text is illustrated by figures and diagrams of important electrical instruments. As in the second edition radium therapy was omitted because of its having become a specialty in itself, so in the third edition the details of x-ray treatment are excluded for the same reason. This edition, as were its predecessors, will be found a helpful manual, especially to those practitioners whose only electrical instruments are faradic and galvanic batteries.

The X-ray Atlas of the Systemic Arteries of the Body. By H. C. Orrin, O.B.E., F.R.C.S., Ed. New York: William Wood and Company. 1920.

An admirable contribution to the study of anatomy is made available for the use of students of anatomy, surgical anatomy, and operative surgery in this x-ray atlas of the systemic arteries of the body. The book is an adaptation to anatomy of the methods employed by the author in his original work of rendering visible the vascular system by x-ray and has been prepared in response to an appeal made by many who have recognized the value of these anatomical radiographs. It is the purpose of the book to provide a series of natural illustrations of the systemic arteries in continuity, precisely as they exist *in situ* in the undissected body; by this method it is possible to display accurately the complete continuity of the vessels, their exact relationship to bones, their finest terminal branches, and the series of anastomoses into which they enter. A series of stereoscopic radiographs also has been inserted at the end of the Atlas. The following arrangement has been adapted with a view to demonstrating most clearly and completely the continuity of the vessels and the relation of one region to another: (1) head and neck, including the arch of the aorta; (2) upper extremity; (3) thorax; (4) abdomen; (5) pelvis and lower extremity. This is a book of rare excellence and unusual value.

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BOSTON MEDICAL AND SURGICAL JOURNAL

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REAR ADMIRAL STITT, M.C., U.S.N., SURGEON GENERAL OF THE UNITED STATES NAVY.

THE appointment of Rear Admiral E. R. Stitt, Medical Corps, U.S.N., to succeed Surgeon-General W. C. Braistead, Medical Corps, U.S.N., retired, assures an era of professional progress for the medical corps of the United States Navy. Both in this country and in Europe, Admiral Stitt has won the esteem of the profession for his work in the field of bacteriology and tropical diseases, for his success as an educator and his attainments in laboratory research, for his scientific textbooks, his example of devotion to duty, of energy and enthusiasm, and for his high standard of accuracy, integrity and patience in professional work.

Rear Admiral Stitt's primary school and college education was received in South Carolina. He received the degree of A.B. from the University in 1885 and the degree of M.D. from the University of Pennsylvania in 1889. He was commissioned Assistant Surgeon in the United States Navy in 1889 and served on various ships and in hospitals and at shore stations for a number of years. In 1905 he served as medical officer of the Nicaraguan Canal Commission, an appointment which gave him an opportunity to become interested in tropical diseases. In 1902 he was ordered to the United States Naval Medical School as instructor in bacteriology and pathology, and had, in addition, the task of organizing and equipping the chemical and bacteriological laboratories of the school which had just been established in Washington, D. C. In 1905 he studied at the London School of Tropical Medicine, obtaining a diploma with distinction from that school. Later on, he had the opportunity of studying tropical diseases in Egypt and the Orient, serving until the latter part of 1906 at the United States Naval Hospital, Canacao, P.I. Returning to the Naval Medical School, he gave instruction in tropical medicine and directed the laboratories of the school. In 1906, he was ordered to command the United States Naval Hospital, Canacao, P. I., and continued this service for two years, at the same time occupying the chair of Medical Zoölogy in the University of the Philippines. He returned to the United States in 1911 and resumed his teaching at the Naval Medical School, serving, in addition, as president of the Examining Board for medical officers of the Navy. Admiral Stitt lectured at various times on Tropical Medicine at George Washington University, Georgetown University, and at Jefferson Medical College. The degree of LL.D. was conferred on him by the University of South Carolina in 1917 and that of Sc.D. by Jefferson Medical College in 1920. During the recent war he served at the Naval Medical School in preparing the medical officers just entering the service and had charge of the laboratory service of the United States Navy. Admiral Stitt's appointment to his new office is a merited recognition of his faithful and efficient service for many years in the Medical Department of the United States Navy.

INFLUENZA IN INDIA.—It has been reported recently that influenza is prevalent in Bombay, Calcutta, Rangoon, and Madras. The Government has adopted precautionary measures and stocks of vaccine are being prepared. Except in Bombay, the outbreaks have not become serious.

SURGEON-GENERAL CUMMING'S REPORT OF THE PUBLIC HEALTH SERVICE.

In the annual report of the Public Health Service, which has been submitted to Congress by the Secretary of the Treasury, Surgeon-General Cumming has discussed, among many other subjects, the matter of appropriations for new hospitals for war risk insurance patients, immigration and quarantine, situations here and abroad, and the loss of personnel to the Service.

In regard to immigration and disease, he has made the following statements:

"With the cessation of hostilities in Europe and the resumption of maritime commerce, the danger of the introduction of epidemic diseases into the United States increased. During the war, sanitation and public hygiene were more or less neglected. In the countries of Central Europe conditions became very favorable for the outbreak of epidemic diseases, and, in many areas infection of typhus, plague and cholera smouldered along, ready to burst forth under conditions that subsequently were sure to arise. The saving feature of the whole situation was the restriction of travel from one country to another. On the resumption of commercial intercourse the expected happened. Even before the armistice, this condition of affairs was foreseen and medical officers of the Public Health Service were sent to Europe for the purpose of investigation and to make preparation for the application of preventive measures at European ports of departure whenever there should be resumed trans-Atlantic travel. At present, officers of the Public Health Service are stationed at practically all of the important ports of Continental Europe for the purpose of inspecting vessels and personnel prior to their departure for ports of the United States. All verminous persons coming from typhus-infected areas are required to undergo appropriate treatment and detention when necessary before embarkation. Notwithstanding this precaution, however, typhus has broken out on several of the vessels bound for ports of the United States, but, with the detection of the disease on the arrival of the vessel and the appropriate treatment of personnel at quarantine stations, the efforts to prevent the introduction of typhus from Europe has proven entirely successful. Measures in force along the Texas-Mexican border to prevent the introduction of typhus from Mexico into the United States have been equally effective. While typhus would probably never cause such a serious epidemic in the United States, as in other countries, it is by no means improbable that the conditions in the tenement sections of the larger cities would be productive of a serious epidemic of typhus if the infection were introduced into such localities."

Dr. Cumming has made the following statement in regard to the legal status of the Public Health Service:

"It is believed to be of the utmost importance that the legal status of the Public Health Service in its war risk work should be firmly established by placing an administrative head over the three major agencies involved, namely, the War Risk Insurance Bureau, the Federal Board for Vocational Education, and the Public Health Service, and that these three bureaus should operate thereunder as coördinate and independent bureaus in close coöperation."

The question of hospital appropriations has been discussed by Dr. Cumming:

"In October, 1919, the department submitted to Congress a program recommending an appropriation of $85,000,000 for the construction and acquisition of additional facilities to meet the growing needs of the service in connection with the care and treatment of war risk insurance beneficiaries. Congress, in its wisdom, however, deemed it unadvisable to appropriate this money for hospital purposes. Since then, the number of beneficiaries has steadily increased, and recent reports indicate that about 20,000 patients were, on July 1, receiving hospital care from the Public Health Service, as against 2,000 when the request was made.

"In addition to increasing existing facilities by the construction of new hospitals, it is desired to bring to the attention of Congress the dilapidated and unsatisfactory condition of many of the hospitals now owned and operated by the Public Health Service. Some of these hospitals have been owned by the Government for years and were used for the treatment of seamen of the merchant marine and other beneficiaries of the service prior to the act which admitted ex-service men of the recent war as beneficiaries. It is presumed that these institutions will be made use of for years to come for these beneficiaries, despite action which Congress might take with reference to the beneficiaries of the War Risk Insurance Bureau. It is therefore necessary that these institutions be placed

in first-class condition. All of the marine hospitals at the present time, with but few exceptions, are of antiquated construction and badly in need of repair. But a few years will elapse before it will be necessary to discontinue entirely the use of these institutions, unless steps are taken to reconstruct and remodel the same to meet with modern ideas of hospital construction and management. Recommendations as to the hospital needs for patients of the Bureau of War Risk Insurance will be presented to Congress in a separate communication.

"The Public Health Service reiterates its firm belief that an adequate hospital construction program should be undertaken by the National Government for the care of ex-service men and women. It is not clear how this responsibility can be adequately met in any other way. It is not believed necessary to go into a very extensive hospital construction program, but certain consideration should be given to a program sufficiently adequate to meet the needs of the situation, and this will mean the expenditure of many millions of dollars. It is repeated that the special needs to be met are those of ex-service men and women suffering from tuberculosis and mental disorders. These groups of patients will require treatment for long periods of time, and their demand is for care and treatment in governmental institutions.

"Despite the temporary increase in compensation granted by Congress during its last session, the Public Health Service, in common with the Medical Corps of the Army and Navy, finds it impossible to secure candidates for admission to the entrance grade of its regular corps, and the attractions offered its scientific personnel are such that the resignations have actually exceeded the admissions during the past 12 months!"

MEDICAL NOTES.

ST. LOUIS UNIVERSITY.—St. Louis University, the oldest seat of learning west of the Mississippi River, has for the first time in its more than a century of endeavor, made a public appeal for funds, the larger portion of which is to be applied to the support of the Colleges of Medicine and Dentistry. The University has asked its alumni and friends to raise the sum of $3,000,000 as a Centennial Endowment Fund, in commemoration of the 100th anniversary of the founding of the institution. The anniversary occurred in 1918, but because of war conditions existing at that time, with over 3,000 of the undergraduates and alumni of the University having answered the call to arms, the celebration was postponed until conditions were more nearly normal. More than fifty per cent. of the faculty and forty-three per cent. of the alumni of the Medical Department of the University held commissions in the Army and Navy at the time the actual centennial date fell.

St. Louis University holds the distinction of having established in the great Louisiana Purchase tract the first colleges of medicine, dentistry, law, and commerce. Its College of Dentistry is the only one in Missouri of Class "A" rating, and together with the Medical College has so expanded that outside aid in the form of an endowment fund is imperative, in order to provide proper salaries for the teaching staff and proper facilities for the two departments. Of the $3,000,000 asked, the income on $1,500,000 is for the salaries of the teaching staffs of the two colleges; the cost of a new laboratory for the School of Medicine is estimated at $250,000; new buildings and clinics for the Schools of Medicine and Dentistry will cost an additional $550,000. The remainder of the $3,000,000 will be applied to the needs of the Institute of Law, School of Commerce and Finance, and the College of Arts and Sciences.

It is hoped by the faculty that old graduates of the Medical and Dental Colleges of the University, who are now scattered all over the world, will appoint themselves a committee of one to aid their Alma Mater to realize the Centennial Fund.

APPOINTMENT OF DR. OSCAR H. PLANT.—Dr. Oscar H. Plant has been appointed professor of materia medica and pharmacology at the University of Iowa, and will become head of the department, to succeed Dr. C. S. Chase. Dr. Chase will remain with the University as full professor and will teach pharmacology and engage in research and writing.

AMERICAN PHYSIOLOGISTS IN PARIS.—The following physiologists attended the congress held in Paris last July under the presidency of Professor Charles Richet: Professor G. N. Stewart, Western Reserve University; Professor Frederic S. Lee, Columbia University; Professor Graham Lusk, Cornell University; Dr. L. J. Henderson, Harvard University; Professor J. J. R. Macleod, Toronto University, and Professor Fraser Harris, Dalhousie University.

Election of Sir William Macewen.—Announcement has been made of the election of Sir William Macewen as president of the International Society of Surgery, which will hold its next meeting, probably, in London during the summer of 1923.

Medical Appointments at Yale Medical School.—Dr. George Blumer and Dr. Wilder Tileston have been appointed clinical professors of medicine at the Yale Medical School. Dr. Blumer resigned last spring from his position as dean of the School. Dr. Edward H. Hume, dean of the Medical School of Yale-in-China, is on leave of absence in this country and will serve as visiting professor of medicine at the Yale Medical School.

Principal Causes of Death: Summary of Bulletin on Mortality Statistics, 1919.—The Census Bureau's annual bulletin on mortality statistics for the death registration area in continental United States, which will be issued shortly, shows 1,096,446 deaths as having occurred in 1919. This represents a rate of 12.9 per 1,000 population, and is the lowest rate recorded in any year since the establishment of the registration area. The rate for 1919 is in striking contrast with the unusually high rate for 1918 due to the pandemic of influenza, which was 18 per 1,000. This is a drop of 5.1 per 1,000 population.

The death registration area in 1919 comprised 33 states, the District of Columbia and 18 registration cities in non-registration states, with a total estimated population of 85,147,812, or 81.1 per cent. of the estimated population of the United States. The states of Delaware, Florida, and Mississippi were added to the area in 1919 and Nebraska in 1920, so that now the only states not in the area are Alabama, Arizona, Arkansas, Georgia, Idaho, Iowa, Nevada, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, West Virginia and Wyoming. The territory of Hawaii is part of the registration area, but the figures given in this summary relate only to the area in continental United States.

Salvarsan Substitutes. — The inclusion in the program of the All-America conference on the Great Red Plague, which meets in Washington early in December, of a discussion of the use of sundry arsenic "substitutes" for arsphenamine (salvarsan) in the treatment of the plague is highly commended by Surgeon-General H. S. Cumming, of the Public Health Service, who has made the following comments:

"Medical officers of the Service and others concerned, were especially cautioned last spring against the use of arsenic preparations not belonging to the arsphenamine group and were directed to use only the arsphenamine produced by licensed firms under the rules and tests prescribed by the U. S. Public Health Service.

"Testing of these arsenic preparations is very neeessary because of their poisonous nature. If not properly prepared, they may be deadly, no matter how carefully they are used, or, what is almost as bad, may be entirely worthless and may delude those who use them with illusory promises of a cure that cannot result.

"Some of the unlicensed preparations that have been foisted on the market were frauds, pure and simple, containing no arsenic or other curative agent at all; but most of these were soon detected and their manufacturers punished. Many of those that are still being made result from efforts to circumvent the rigid tests required by the Public Health Service for the protection of the public and to market substitutes which are sold with unwarranted claims as to their curative value.

"Salvarsan (606) was devised by Ehrlich in 1910, after 605 unsuccessful experiments in trying to find a preparation of arsenic that would kill the germs in the patient's blood without also killing the patient. It was carefully protected by patents, taken out in Germany and elsewhere, that which enabled enormous prices to be charged for it. During the war, inability to import it from Germany, where it was chiefly manufactured, caused the United States to seize the patent rights and to authorize manufacture in this country.

"Later, in an effort to standardize the drug and to prevent the sale of worthless substitutes, the name 'arsphenamine' was adopted; and licenses for its manufacture were granted by the Treasury Department to all persons who complied with certain conditions that were considered essential for safety and health.

"No one who does not comply with these regulations may call his product 'arsphenamine'; but there seems to be no law to prevent the manufacture of substitutes bearing other names and claiming to obtain the same results."

Several firms are now manufacturing arsphenamine and neo-arsphenamine under licenses from the Treasury Department. Their products are rigidly inspected and tested by the U. S. Public Health Service; and these products alone are used in the various hospitals and clinics of the Service.

BOSTON AND MASSACHUSETTS

THE WEEK'S DEATH RATE.—During the week ending Dec. 25, 1920, the number of deaths reported was 179 against 221 last year, with a rate of 12.48 against 14.47 last year. There were 31 deaths under one year of age against 45 last year.

The number of cases of principal reportable diseases were: Diphtheria, 56; scarlet fever, 30; measles, 36; whooping cough, 18; typhoid fever, 1; tuberculosis, 39.

Included in the above were the following cases of non-residents: Diphtheria, 4; scarlet fever, 5; tuberculosis, 9.

Total deaths from these diseases were: Diphtheria, 1; scarlet fever, 1; whooping cough, 1; tuberculosis, 12.

Included in the above were the following non-residents: Diphtheria, 1; tuberculosis, 2.

DISTRICT NURSING ASSOCIATION.—At a recent meeting of the Greater Boston Committee of the Instructive District Nursing Association it was reported that the number of district nursing visits for May, 1920, was 26,552, as against 19,739 in May last year. There were 2,358 new patients during the month of May in this year, compared with 1,570 new patients cared for by the association staff in May of the previous year.

HARVARD INFANTILE PARALYSIS COMMISSION.—The fund for the work of the Harvard Infantile Paralysis Commission has reached a total amount of $14,755. As about twenty-two per cent. of the six hundred and fifty children reported afflicted with infantile paralysis during the past three months have already gone to the Commission for treatment, further funds are greatly needed in order that this new group, as well as the previous ones, may be assured treatment for the coming year.

MEDICAL BEQUESTS.—By the will of the late Thomas Jefferson Coolidge of Boston, the sum of twenty thousand dollars is bequeathed to the Massachusetts General Hospital. A bequest of an equal sum has been left to the Harvard University to be added to the Thomas Jefferson Coolidge Fund, the income only to be used for research at the Jefferson Physical Laboratory.

MEETING OF NEW ENGLAND SOCIETY OF PSYCHIATRY.—On invitation of the superintendent, Dr. Arthur V. Goss, and Trustees, the semi-annual meeting of the New England Society of Psychiatry was held at the Taunton State Hospital, Wednesday, Oct. 27, 1920. The president, Dr. Walter E. Fernald, presided. Program:

1. "Acaraphobia. A Dermatological Psychosis." Dr. Abraham Meyerson, Boston.
2. "Mental Responsibility and Petty Crime." Dr. D. A. Thom, Boston.
3. "Defeetive Delinquents in the Army of Occupation, or the American Forces in Germany. How They Are Treated in the Disciplinary School."

Lt.-Col. L. Vernon Briggs, M. R. C., U. S. A., Boston.

Seventy members and guests were present. Before the meeting, an invitation was extended to the members to visit the various departments of the institution.

Correspondence.

MEDICAL LEGISLATION AND MATERNITY AID.

Deerfield, Mass., Dec. 2, 1920.

Mr. Editor:—

When, last January, at our Franklin District meeting in Greenfield, Dr. Worcester quoted one of our leading legislators, Mr. B. Loring Young, as saying that a maternity aid bill was very likely to be passed at that session, I was struck with quite a degree of surprise, knowing something of the hard fight new measures have to go through. Eight years ago I put in a bill for road supervisors for small towns similar to a bill already in effect for school supervisors. This was a matter of economic importance affecting the circulatory life of rural communities which country practitioners can well appreciate. Dr. N. P. Wood of Northfield, who had been in the legislature, and I took a good deal of trouble to go down and argue in its behalf for three winters. Though the bill did not pass, as the Highway Commission argued that under existing legislation they could furnish supervision if called upon, it did emphasize special needs of the small towns and has had a wholesome moral and educational effect. Supplementary legislation has been since obtained for the Highway Commission and small towns have now more practical inducements to avail themselves of such a form of supervision.

Another measure with which I have had to do was stimulated by the dramatic results of fresh-air treat-

ment upon tubercular cases. If this treatment (out door living) is good for the sick, it should add more vigor to the well. I left practice in the city to get more of the outdoors of the country. Conservation, business, sentiment interested me in forestry. Through an experiment I was led to make, I became satisfied that the science of forestry could be made to pay profits in money and, if put more into practice, would furnish an increasing amount of outdoor labor of an interesting kind. I introduced the Mt. Grace Forest measure back in 1914, thinking it would preserve a beauty spot, appeal to the imagination, stand directly for conservation of physical resources and from one viewpoint, at least, in furnishing outdoor employment might serve to a degree for conservation of human health. It has taken *seven years* of hard and persistent work to get this bill through.

It takes *time* to ripen good fruit. Sound legislation must have the continuous coöperation of all interests involved. A maternity aid bill cannot be well matured without the interest, counsel, work and support of the medical profession at large. In provisions for state and community service the medical profession seeks only to have mutual relationships satisfactory.

Sincerely,

Paul W. Goldsbury, M.D.

A GREETING FROM ST. DUNSTAN'S.

Mr. Editor:—

This the season of greetings and gifts.

May I send to your readers greetings and ask them to send me gifts?

These greetings will, I hope, give real pleasure. They convey the gratitude of the soldiers blinded in the war, for the sympathy and help which has come to them from all parts of the world. They carry the news that all we hoped for from the training given at St. Dunstan's is being justified by these blinded men in the very wonderful success that they are making of their lives.

I do not think that anyone would say it gets easier to be bravely blind as the years go on. It becomes easier to do things in the dark, but the demand on the will to keep pace with normal life grows greater rather than lessens. Constant effort is extraordinarily exacting, and it is really splendid how the men meet this demand on themselves, keep up their interest in everything and maintain their notable record as workers; some in offices, some practising as masseurs, some as poultry farmers, and others as expert craftsmen.

There are still more than five hundred men learning to be blind in our class-rooms and workshops.

Besides those actually blinded on the battlefields, 23,000 men were discharged from the army with seriously damaged sight, and, unfortunately, many of these are finding it necessary to come to St. Dunstan's. We are dealing, too, with a number of men whose health does not enable them to make such quick progress as others. At the same time, it becomes increasingly difficult to find for the men who are ready to start on their new life, suitable homes: there is a universal shortage of houses and a great scarcity of such small properties as the poultry farmers need. Thus the difficulty and expense of settling the men has increased while we have to face enormously multiplied costs in providing for those who are our guests, in maintaining our convalescent and holiday homes, and in carrying on the ever-increasingly important work of the after-care of the blinded soldiers.

We have also to meet the expense of moving our headquarters—the offices for the organization required to look after nearly 2,000 men, and also the class-rooms and workshops. The house with its beautiful grounds so generously lent by Mr. Otto Kahn as a hostel is no longer available. Fortunately, however, we have been able to find for our new quarters another house in Regent's Park—a place which for several generations has been the London home of the Marquesses of Bute. The interior has been adapted for offices and in the gardens the class-rooms and workshops have been re-erected. The place is near the lake on which the blinded soldiers have taken so much pleasure in rowing, and both from the point of view of fresh air and of opportunities for unimpeded exercise, the situation is ideal.

This starting again in the creation of a new training center for the blinded soldiers has, however, been no small matter, and it adds to the reasons already referred to which prompts this appeal for the generous help of your readers.

The blinded soldiers have created a magnificent record; the plans for helping them back to normal life have worked out better, I think, than anyone dreamed would be possible. I think, too, there is no one who realizes what the gift of sight means and what blindness must mean, who would not wish to help on this work which St. Dunstan's has undertaken.

I trust that any of your readers who are so generous as to respond to this appeal will forward their contributions to me at St. Dunstan's Headquarters, Regent's Park, London, N. W. 1.

Yours faithfully,

Arthur Pearson, *Chairman*,
Blinded Soldiers' and Sailors'
Care Committee.

ABDOMINAL MASSAGE AND DR. DROWNE.

Boston, Dec. 4, 1920.

Mr. Editor:—

All honor to Dr. Drowne for his courageous departure from the beaten tracks of medicine and surgery, and taking an excursion into the by- (and often forbidden) paths of massage of the abdomen.

His biographers make an unnecessary mystery of his methods, and even insinuate that he kept them to himself. Massage of the abdomen and its variations are simple enough, and fully described in my Treatise on Massage, which Dr. Drowne and his friends seem to be entirely ignorant of. But the results to be obtained thereby are numerous and far-reaching. I have already described many of them in my book, which some of the osteopaths call their Bible, and more revelations await the open-minded investigator. For the present, suffice it to say that the subjective symptoms can almost all be got rid of by means of massage, and, if the disease is not malignant, there need be no hurry about operating.

Dr. Drowne sent me one of his abdominal patients to learn massage, with the expectation that she would be his assistant. When she had finished with me, she said she was not going back to him as she considered what she had learned so very much better than the way she had been treated that she was not going to show it to Dr. Drowne and his assistants. Noble sentiment for a sage from Concord!

Dr Weir Mitchell made his everlasting reputation by the use of general massage in rest cases; Major Thure Brandt, by massage of the pelvic organs in women; Julius Wolff, by massage and exercises in writer's cramp; Mezger of Amsterdam, by massage in joint cases; and now we have the spectacle of the European oculists losing their heads on massage of the eye, claiming results from it that surpass the miracles of Scripture, and saying that they have always been in favor of it, when we know very well that less than twenty-five years ago they could not say enough against it.

Douglas Graham, M.D.

SOME TIMELY TOPICS.

Mr. Editor:—

Several representations have come to me complaining of the undue influence of some insurance companies over some Industrial Accident Boards in the matter of cutting the regular fees of attending physicians, and some other acts outside their sphere. Whenever any member of any such board by word or act seeks to deprive any sick or injured persons of their constitutional right to choose their own physicians or to compel such to submit to the treatment of physicians hired and controlled by insurance companies, thereby letting such companies take them by the throat and preventing them from having any witness of their own, then every physician in such state who is true to his profession and to the interests of the people should at once sign a petition to the Governor for the removal forthwith of such member. If the Governor fails to do so, then see that he and his adherents are retired at the next election. Several victims have told me that when they refused to be throttled by insurance companies and exercised their right to choose their own physicians the insurance companies threatened not to pay them anything and advised the patient not to pay the physician, thereby laying themselves liable for collusion, if not conspiracy, to defraud.

Compulsory health insurance is a Socialistic scheme to deprive and rob the people of their constitutional rights for the benefit of profiteering money interests imported from anarchistic Europe where it has been a failure, and should be deported together with its propagandists. Is the medical profession to be socialized, dominated and its individuality, initiative and usefulness destroyed by any profiteering combinations or their hired politicians? Quite different from the services rendered to the public and the country by the medical profession in both war and peace! Every physician should instruct his clientele forthwith in regard to these matters and arouse them from any unthinking docility. When insurance companies of our state collect from the people over $33,000,000 in one year and pay back to them only $9,000,000, would not the people be better off to have the over $24,000,000 in their own hands or banks rather than in the insurance company's bags?

All citizens of this country, officials or propagandists, who violate the United States Constitution or by fraud or compulsion seek to deprive any loyal citizens of any of their constitutional rights and liberties are traitors and inciters of revolution and should be treated as such, and will be when the people are fully awake—and they are awakening. The king and dictator business, together with the unconstitutional compulsory business is passing, whether existing under the guise of crowned heads, or uncrowned and unscrupulous moneyed combinations, or as mercenary politicians who should never be elected to any office a second time. Physicians will not quietly submit to being robbed by unconstitutional compulsory methods of their clintele, whose confidence and esteem they have won by long years of faithful and efficient service for the people. Nor will the people long submit to being deprived of any of their constitutional rights and liberties by unscrupulous schemers or monomaniacs. In this country all officials are servants of the people, not their masters, and must obey as well as enforce the laws or answer to the people.

EDWIN A. SANBORN, M.D
24 Franklin St., Somerville, Mass.

Miscellany.

THE next annual meeting of the Massachusetts Medical Society will be held in Boston, Tuesday, May 31, and Wednesday, June 1, 1921.

RECENT DEATHS.

DR. ORLANDO B. DOUGLAS died recently at Concord, New Hampshire, at the age of eighty-four. Dr Douglas specialized in eye, ear and throat diseases. He was associated with many organizations; he had been president and treasurer of the Medical Society of the County of New York, treasurer of the New York Academy of Medicine, member of the New York State Medical Society, the New Hampshire Medical Society, the New Hampshire Surgical Society, the New Hampshire Association of Military Surgeons, and honorary member of the Vermont Medical Society. Dr. Douglas married, in 1864, Miss Mary A. Rust of Orwell, Vermont. After her death he married Miss May L. Mason, in 1875. He is survived by one son, Edwin Rust Douglas of Philadelphia.

DR. FRANK MARTIN of Baltimore, Md., died recently. Dr. Martin was a graduate of the University of Maryland. On March 1, 1916, he married Miss Elizabeth Prescott Bigelow of Boston.

The death is announced, at the age of seventy-six years, of DR. THÉODORE FLOURNOY, formerly professor of physiology and psychology at the University of Geneva.

DR. JOHN OLIVER MARBLE, a retired Fellow of the Massachusetts Medical Society, died at his home in Worcester, at the age of 81. The son of John and Emeline Prescott Marble, he was born in Vassalboro, Me., was graduated from Colby University in 1863, and from the Medical Department of Georgetown University in 1868. He settled in Worcester in 1870 and was one of the medical staff of the Worcester City Hospital for 20 years. He was a director of the Worcester Free Public Library and many clubs. He retired from practice in 1896. His wife, who was Helen M. Allen, died several years ago.

DR. WORTHINGTON WARNER MINER of Ware, died at his home December 19, 1920, after an illness of six months. His death was due to anemia. He was born in Ware Nov. 5, 1847, and was the son of Dr. David Worthington Miner and Mary Warner Miner.

He was graduated at Amherst College in 1868, and received the degree of M.D. from the University of Buffalo, N. Y., in 1871. He was for eight years assistant to his uncle, Dr. Julius F. Miner, a surgeon of Buffalo. At the same time he was attending surgeon at the Buffalo Hospital of the Sisters of Charity, and lecturer in the summer course of the University of Buffalo. He was also associate editor of the *Buffalo Medical Journal*.

In 1880 he joined his father, the late Dr. D. W. Miner of Ware. He had been medical examiner of the fourth Hampshire district since 1894. He was surgeon for the Boston & Main Railroad and of the Otis Company, the Gilbert and the Stevens mills at Ware for twenty-five years. He served also as surgeon for the Ware Lumber Company and for the Wood Boot and Shoe Company.

He was a member of the Brookfield Medical Club, the Hampshire District Medical Society, of which he was president in 1908-1909, the Springfield Academy of Medicine, the Massachusetts Medical Society, the New York and New England Association of Railway Surgeons, the Clinical and Surgical Association of Massachusetts, the American Medical Association and the Clinical Congress of Surgeons of North America, and of the Massachusetts Medico-Legal Society. He was on the staff of physicians and surgeons of the Ware Visiting Nurse and Hospital Association.

He held various town offices, that of school physician, chairman of the board of health, member of the school committee and member of the Ware Study Club, the Library Association, the Eden Lodge of Masons, and the King Solomon Chapter of Royal-Arch Masons.

Dr. Miner is survived by two sisters, Miss Jean E. Miner of Ware, and Mrs. Charles A. Tuttle of Middletown, Connecticut, and by one nephew and one niece.

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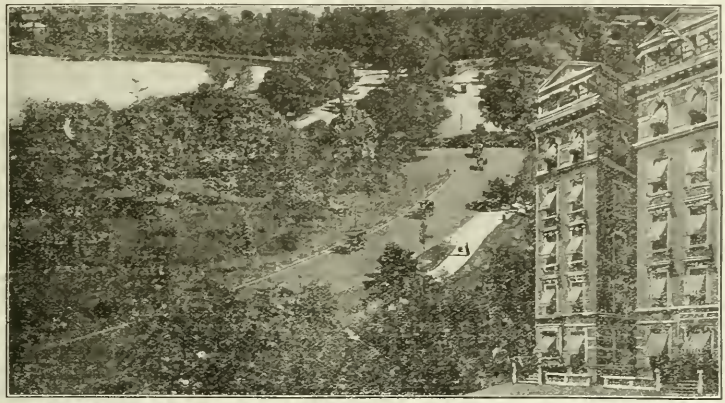

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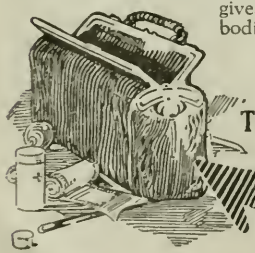

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